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DUTIES OF THE DERMATOLOGIST*

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Under ordinary circumstances it would be both easy and proper to point out many duties that confront the specialist in general and the dermatologist in particular; but in these times it seems necessary to mention only a few. Accordingly, five phases will be considered, namely, the duties of the special societies, certain duties to the patient that have not been sufficiently recognized, the need for developing more and better dermatologic clinics, the arsphenamin situation, and lastly the duties to the country.

THE WORK BEFORE DERMATOLOGISTS

For years many of us have felt that the various societies composed of specialists, as well as many of the special sections of the American Medical Association, have not fulfilled all that might be reasonably expected of them. They are rather pleasant social meetings with a sprinkling of good papers and some valuable discussion, both public and private, rather than beacons in the progress of science. Would it not be fair to ask that such societies should be the sources of authoritative information from which the general practitioner could gain help, from which the lay citizen could seek advice, or the government aid? A standing publication committee which should from time to time publish critiques or be prepared to answer proper queries would be valuable. Also it might be well to assign certain definite problems to members who are in a position to throw light on them: committee reports each year on certain important questions, such as radium treatment or the standardization of the Wassermann test might also be of extreme value. Of course the present is no time to act on such suggestions, but in the future it might be wise to consider certain of them.

DUTIES TO PATIENTS

In such a paper as this it is naturally impossible to discuss all that a specialist owes to his patients; nevertheless, one important thing must be emphasized, namely, the duty to recognize certain serious ailments that may be in the process of evolution. Those of us who have been interested in cancer propaganda have long maintained that the general practitioner, the internist and specialists in most lines have failed to note certain blemishes that might later develop into malignant conditions. Only too often does the specialist fail to realize that the condition which brings a patient under his observation may be but one symptom of some constitutional disease; the dermatologist may treat urticaria or a so-called acute eczema without knowing that the patient has a disturbance of the vegetative nervous system that is the direct cause of the local skin condition. Pruritis may be due to some disordered mental process. One noteworthy case of intractable eczema was directly due to a feeling of scrupulosity and hence excessive bathing, the primary mental condition being due to incest committed years earlier in life. Sweaty hands are frequently due to an oversecreting thyroid; sweating feet to weak arches; chronic urticaria to focal infections, syphilis or vagotonia, as well as to faulty digestion. If each and every one of us would more frequently refer his patient to a man who made a specialty of both physical and mental diagnosis, not only would more of our patients be relieved of cutaneous afflictions, but many a valuable man would be saved from later becoming a wreck.

POSTGRADUATE INSTRUCTION IN AMERICA

There can be no question that, in the past, certain cities in Germany and Austria have been the mecca for the training of American dermatologists. It is true that too often this has been a fad rather than a necessity; and, sad to relate, many a fledgling has learned to believe that all that is dermatologically good has and must come from Teutonic sources. Possibly if he had gone a bit deeper into his subjects he would have learned that frequently his professor or privatdocent was either too conceited or too ignorant to even know of the work that had been done in America, or that he wilfully chose to disregard it.

To some of us it has always been a marvel that more of us could not see through the folly of taking too seriously the work of a man who would dare to publish a bibliography of seventy-odd names, four French, one English, none American and the remainder German. However, it is extremely probable that the future dermatologist will not care to be trained in a city from which have emanated orders to use poisonous gases, to torpedo hospital ships and to bomb hospitals. In the United States we must prepare to train dermatologists and syphilologists, for the study of syphilis is coming into its own as the result of freer discussions necessitated by the war. We should now lay our plans to develop great clinics in which students and physicians can be thoroughly trained. Our dermatologic material has been too much scattered: in each city it should be more centralized for teaching purposes, so that the student can see a wealth of material. In addition, each dispensary should have its own laboratory attached, and there should be a number of hospital beds, both for severe dermatologic cases and for intraspinal work. Until we make up our minds to have fewer and better clinics we cannot hope to

* Chairman's address, read before the Section on Dermatology at the Sixty-Ninth Annual Session of the American Medical Association, Chicago, June, 1918.

give proper training, and it is distinctly up to the dermatologists to see to it that plans are now made.

THE ARSPHENAMIN SITUATION

There is no physician who does not remember how we Americans have been robbed as a result of the monopoly on arsphenamin (salvarsan). At present the situation is much better, thanks largely to the wisdom and foresight of one man, Jay Frank Schamberg of Philadelphia, a dermatologist. It is difficult to conceive of a treaty of peace that does not include the restoration of patent rights: when this time comes what must we pay for a drug that is many times more necessary than is diphtheria antitoxin? If we are thrown on the mercy of the German manufacturing house we need not expect prices that will enable the poor to be provided with it, and if by any chance the patent right should be assigned to the former distributors of the drug in this country, it is difficult to see how we should be any better off. As a proof of the latter point you are invited to read the testimony of Mr. Metz before Congress one year ago, when the abrogation of the patent rights on salvarsan was being discussed. Also, what guarantee should we have that a pure drug was being marketed? Certainly when a manufacturing house threatens to sue physicians for reporting unfavorable results, as the Farbwerke-Hoechst Company has done in the case of Dr. Sargent, we must believe that it is more interested in the financial than in the humanitarian side. As a public health proposition it is our duty to urge that salvarsan be specifically excluded when patent rights are being restored.

DERMATOLOGISTS IN ACTIVE SERVICE

Seven score and two years ago a great American patriot wrote, "These are the times that try men's souls." Once again do these words come home to every man of us, and each must ask himself, "What is my duty?" Many of our dermatologists have answered the question directly by entering one of the government services. Among these men are Pusey and Baum of Chicago, and Pollitzer, Fraser, Howard Fox, Fred Fox, C. M. Williams, Clark and Johnson of New York, the last of whom has recently died as the result of his devotion to duty. Still others are Wile of Ann Arbor, Dyer of New Orleans, Markley and Lingenfelter of Denver, Knowles and Gaskill of Philadelphia, Mook of St. Louis, Pudor of Portland, Sayles of Taunton, McBride and Dennie of Kansas City, Goldstein of Fort Smith, Chipman of San Francisco, and Oliver, Lee, Cheever and Howe of Boston, the last named having been killed in France. Also there are many others who have given freely of their time and strength in connection with the work of the draft boards or with local health problems. But for the rest of us, what is our duty? Certain men there are who cannot or should not offer their all. In this group may be placed those past 55 years of age, those who have some physical defect, those whose teaching or clinical positions cannot be filled, certain men in practice whose places cannot be filled, and some few who are in financial straits. Let us examine these criteria a little more closely.

Physicians over 55 are not considered eligible for the Medical Reserve Corps, and yet there are plenty of men past this age who are capable of doing hard work and who fill responsible positions at home. Many good men have been barred on physical examination because of some slight physical defect; some at least of these men could render valuable services in certain selected capacities. We all realize that under no circumstances can the Army be burdened with physicians who may break down under stress, and a rigid physical examination is an absolute necessity. A moment's thought will make all realize that physicians are a necessity to the community, and it would indeed be a short sighted policy that would permit our medical schools to be closed or which would deprive them of too many instructors. Furthermore, our clinics and hospitals must continue to render efficient service, for the continued good health of our population will be a great asset both during this war and in the more or less unsettled times that are sure to follow it. At the same time it is questionable if we do not have too many medical schools and far too many clinics. If certain of our schools could combine for the period of the war, many instructors could be spared; and if the weaker of our clinics and dispensaries should close their doors, only good would result. In practice there are a number of men whose services cannot well be spared. Many physicians in rural districts simply cannot be replaced at the present time. Men who are the only representatives of their specialty in a wide area may be vitally necessary, and some physicians to large industrial concerns would be more than sorely missed. There is now less financial excuse would gladly give part of their time for government has passed certain new legislation, but nevertheless it is hard for a physician who has borrowed money to educate himself, and who is now paying for a house and educating his children to accept a much smaller salary.

Many physicians in the classes enumerated above would gladly give part of their time for government work. It would seem perfectly possible for the Surgeon-General's Office to arrange that in the government hospitals, camps and cantonments there should be a visiting staff of civilian physicians, who should act in precisely the same capacity that many of them now act to the great civilian hospitals. They should, of course, be assigned certain definite hours and compelled to observe them. By such an arrangement as this several things could at once be accomplished: the physicians would not feel that they were remiss in their duty, troops would secure the very best medical attention, for specialists in various lines would be at their disposal, Army physicians would secure additional expert training, the medical schools could continue their work unhampered, the civil population would not suffer, and many Army physicians would be set free for more strictly military duties. At the same time we must all appreciate the tremendous difficulties that have been associated with the expansion of the medical corps and express a word of appreciation for the excellent work that has been done; this idea that has just been elaborated is not to be viewed in the light of a criticism but rather as a suggestion that many of us believe to be well worth considering.

A MOTTO FOR THE MEDICAL PROFESSION

Lastly, let us waste no time, but let us conserve our strength. Let us keep our tempers, let us not become hysterical, let us not be led into hasty judgments even though the medical mouthpiece of the Council of National Defense continues to utter fulsome fulminations. And in deciding what to do, let us be governed by one rule: Do what will be for the greatest good of the greatest number.

RELIABILITY OF OZONE IN SWIMMING POOL DISINFECTION *

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It is now well established that the combination of refiltration and disinfection of swimming pool water constitutes the standard procedure in the sanitary control of plunge baths. It is also well known that the combined procedures of refiltration and disinfection effect reductions in the cost of maintenance which, in the long run, make the installation of expensive apparatus an actual economy. Furthermore, it is well to state that refiltration can be relied on in a properly designed system to maintain the pool water free from suspended matter, and that ozone treatment will supplement this by bleaching dissolved coloring matter and by destroying bacteria.

In diseases, bacteria are discharged from the body in pus, mucus, feces or blood. The bacteria are usually protected by these substances from the destroying activity of such natural agencies as light and drying; and probably the success obtained by the use of strong oxidizing chemicals, such as gaseous chlorin, the hypochlorites and ozone, may be attributed to the power these substances have of destroying the organic material enveloping the bacteria. Methods applied without regard to bacteria protected in this way usually fail in practical operation, even though excellent laboratory results are obtained when artificial cultures are used.

In swimming pools, in which there is always a greater load of organic matter than in the average water supply, it is of particular importance to select powerful oxidizing agents as disinfectants. Of these powerful agents we should consider the halogens and ozone.

THE HALOGENS.

In large water supplies, gaseous chlorin and the hypochlorites have in a great many cases been used with perfect success. In smaller systems they have occasionally failed, owing merely to the fact that objectionable tastes and odors were produced in the water when a sufficient quantity of chemical was used to insure sterilization. In swimming pools in which large quantities of organic matter are constantly introduced into the water, correspondingly large amounts of chemical must be added to insure thorough oxidation and adequate destruction of bacteria. For this reason it has been quite usual to find either one of two conditions obtaining in a pool in which chlorin or its compounds are used—namely, the addition of insufficient chemical, resulting in inadequate purification, or the addition of a superfluous amount with the production of tastes and odors making the water at times almost unfit for use. Consequently while from the bacterial point of view the halogens are quite efficient in pool water purification, they frequently fail in practice because they tend to reduce the patronage and therefore the usefulness of the pool.

OZONE.

The addition of a powerful oxidizing agent to pool water, in such an excess as to insure destruction of bacteria, though leaving no objectionable trace in the water, is particularly valuable in pool disinfection. Ozone is the only economically produced chemical of which we know that can be relied on to destroy the bacteria, bleach the coloring matter, successfully attack the organic substances, and at the same time leave no objectionable substance in the water. In fact, the process thoroughly aerates the water and enhances its appearance.

There is, of course, nothing novel in the successful application of ozone to the purification of large drinking water supplies. Spalding[1] states that forty-nine large ozone plants abroad regularly deliver pure water to large municipalities. In France he cites twenty-six plants, in Roumania four, in Spain one, in South America three, in Germany seven, in Italy five, and in Russia three. The plant at St. Maur supplies the city of Paris with 24,300,000 gallons daily, the Bon Voyage plant supplies Nice with 6,480,000 gallons daily, the plant at Villefranche supplies 7,020,000 gallons daily, and the plant at Petrograd supplies 14,040,000 gallons daily, to mention only some of the largest. It is evident, therefore, that the use of ozone in pool water purification is merely another instance of its successful application.

TESTS.

The summary of a series of tests has already been set forth,[2] from which I quote in part:

> The bacterial counts in this pool (Twenty-Third Street Bath) were so low after continuous operation of the ozone machine that it was deemed advisable to add a large number of *B. coli* to the water in order to observe the efficiency of ozone on heavily polluted water. Accordingly a mass culture of *B. coli* was emulsified in salt solution and thrown into the pool. In order to secure thorough mixing of the bacteria with the pool water and to keep the pollution high, the circulating pump was shut down between 10 a. m. and 2 p. m., a long handled brush was used to stir the water, and this, together with the agitation produced by the bathers, resulted in a uniform mix. The pool was then operated as usual and two hours later the tests were made.
>
> ONE PART OF OZONE PER MILLION OF WATER
>
> (NOTE.—All bacterial counts are averages of 3 or more determinations.)
>
> Using ejector:
>
> Bacterial count in artificially infected pool, 3,700 per cubic centimeter.
> After filtration and before ozonation, 1,800 per cubic centimeter.
> After ozonation, no growth in 1 cubic centimeter.
> After ozonation, no growth in 3 cubic centimeter.
>
> In addition to plating 1 c.c. of the water delivered from the ozone tower, 3 c.c. samples were plated as well. In the majority of cases no growths were obtained.
>
> Using blower:
>
> Pool water in artificially infected pool, 3,500 per cubic centimeter.
> After filtration and before ozonation, 1,540 per cubic centimeter.
> After ozonation, no growth in 1 cubic centimeter.
> After ozonation, no growth in 3 cubic centimeters.
>
> The results, using the blower, are identical with the foregoing. We conclude, therefore, that when one part per million of ozone is used, either with an ejector or with a centrifugal air blower (which delivers more air) the pool water artificially contaminated with *B. coli* is sterilized.

If one-half part ozone per million of water is used, the ejector, delivering less air than the blower, gives better results. Indeed, one-half part per million seems to be ample for average conditions.

A recent extensive series of tests was made to obtain data on which to judge the reliability of the process

* From the Research Laboratory of the New York Department of Health.
* Read before the American Association for Promoting Hygiene and Public Baths, Newark, N. J., May 15, 1918.

1. Spalding: Application of Ozone to Water Purification, N. Y. State Dept. of Health, 1913.
2. Manheimer, W. A.: The Application of Ozone to the Purification of Swimming Pools, Pub. Health Rep., 1918, 33, 267.

over an adequate period of time. These tests were made on alternate days three times a week for a period of three weeks without renewing the water. The results are set forth in the accompanying table, so as to show the uniformity obtaining:

RESULTS OF TESTS

First Week		Second Week		Third Week	
Before Ozonation	After Ozonation	Before Ozonation	After Ozonation	Before Ozonation	After Ozonation
58	1	10,800	1	31	0
85	0	16,300	0	35	0
80	0	8,400	1	22	0
50	0	15,000	0	23	0
60	0	.....	1	36	0
7,500	0	12	0	1,600	0
5,000	0	12	0	1,700	0
4,800	0	8	1	.....	0
6,000	0	14	0	1,700	0
5,000	0*	21	0	1,500	1
12,'00	0				
1,800	0	18	0	60	0
1,800	0	21	0	100	3
2,000	2	22	0	90	0
1,400	1	30	0	80	0
		29	0	80	0

* Two surface.

The attendance in this pool is exceptionally large, reaching at times 1,500 bathers a day. This necessarily causes high pollution. It will be observed that the water was delivered sterile, or nearly so, regardless of the counts before ozonation. In addition to this the water was bleached, gradually assuming a transparent blue, so that as the pool continued to be operated the appearance of the water was improved. Consequently where adequate refiltration is combined with ozone disinfection, the water may be retained in the pool for a considerable length of time, effecting a material reduction in the cost of maintenance. It should be stated, however, in designing a pool, that the capacity of the recirculation system should be proportional to the estimated attendance.

COST OF OPERATION.

The cost of operation for a 60,000-gallon pool is low. Only two items need be considered, the amount and cost of electric current, and the cost of the occasional replacement of calcium chlorid in the air dryer.

Alternating current must be supplied to the ozonator. If only a direct current is available, it must be converted into alternating current by means of a motor generator. This entails a current consumption of 2 kilowatts a day for a six-tube ozone unit (the unit to be used for a 60,000 gallon pool). The unit itself will consume only 2 kilowatts a day, so that if alternating current is available the cost of operation will be from 11 to 15 cents a day, allowing 1 cent for the replacement of calcium chlorid and figuring electric current at the rate of from 5 to 7 cents a kilowatt. If electrical current is manufactured on the premises the cost may be materially reduced below the figures stated. Where direct current must be converted into alternating current, from 10 to 14 cents (2 kilowatts) must be added to these figures.

It is obvious that the process is very economical in operation as well as reliable and automatic in control, and for these reasons is destined to wide application in the purification of swimming pools.

CONCLUSIONS.

Ozone is recommended for swimming pool purification because:

1. It is reliable as a disinfectant.
2. It is capable of purifying heavily polluted pool water.
3. It produces no objectionable substances in the water.
4. It improves the appearance and transparency of the water, permitting a longer continued use of the pool, a consequent reduction in the cost of maintenance, and a reduction in the hazard of drowning.
5. It is inexpensive in application.

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THE ACTION OF MIOTIC DRUGS ON EYES WITH INCOMPLETE SPHINCTER IRIDIS *

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In the literature of glaucoma and ocular injuries, there are contradictory opinions expressed on the effect of miotic drugs in cases of incomplete sphincter, especially in radial tears of the iris from contusions, leaving it a matter of conjecture whether such radial tears can be increased or diminished by the use of miotics. There is the same contradiction of opinion on the effect of mydriatics on radial tears. Regarding glaucoma, it seems generally to be assumed that the beneficial effects of the miotic drugs are due entirely to the contraction of the sphincter, and that these beneficial effects are abolished if the sphincter is not intact and functionally capable. On the other hand, it is frequently advised that treatment with miotics be given after iridectomy, in case of insufficient effect from the iridectomy, thus recognizing — or hoping — that the miotics may still be effective.

Elliott,[1] in objection to complete iridectomy in sclerocorneal trephining for glaucoma, says:

> It deprives the surgeon of the power of inducing strong miosis should he require to do so.

Johnson,[2] on the operative treatment of glaucoma, says:

> Suppose that the iridectomy has already been performed without permanently reducing the tension, what is one to do then? The ring of the inner circle of the iris has been divided and miotics will no longer act effectively.

Fuchs[3] says:

> Eserin . . . in many cases excites violent headache, which may lead to vomiting. These symptoms are not to be regarded as due to a general poisoning, but are caused by the marked contraction of the pupil, by which the nerves of the iris are strongly pulled upon. Hence, the symptoms are absent when marked contraction of the pupil fails to take place—e. g., in atrophy of the iris or in solutions of continuity of the sphincter (colobomata, fissures, etc.).

In the later edition, this paragraph is changed:

> Eserin frequently excites severe pain in the eyes and head, painful contractions in the lids, and even nausea and vomiting. These are not symptoms of poisoning, but are the results of the great narrowing of the pupil and the contraction of the ciliary muscle, by which the ciliary nerves are pulled upon. This bad by-effect, therefore, usually is absent when,

* Read before the Section on Ophthalmology at the Sixty-Ninth Annual Session of the American Medical Association, Chicago, June, 1918.

1. Elliott: Ophthalmoscope, 1914, **12**, 587.
2. Johnson: Arch. Ophth., 1914, **43**, 8.
3. Fuchs: Textbook of Ophthalmology, Third American Edition, 1908, p. 308; Fifth American Edition, 1917, p. 389.

for any cause, the eserin fails to produce any marked contraction of the pupil.

Beard,[4] writing of anterior sclerotomy with conjunctival bridge, says:

A prolapse under the existing conditions could not be adequately dealt with, and an iridectomy would be undesirable in view of the possible need of miotics at a later period.

Again, on the efficiency of iridectomy:

In the event of a relapse, it precludes the use of miotics.

Bradburne[5] says:

This operation (basal buttonhole iridectomy), in that it leaves the pupillary border of the iris intact, allows the subsequent employment of miotics if such be deemed necessary.

Fig. 1.—Size and shape of pupil (a) before and (b) after physostigmin.

Bernheimer,[6] reporting a case of congenital anomaly of the iris, observed six large round indentations of the pupillary margin, and within these three or four parallel folds of iris tissue which corresponded to smaller indentations. He says:

The fact that the pupil reacted to light and contracted upon eserin, although not maximally, proved that the changes were only superficial disturbances of the arrangement of the tissue of the iris, and did not involve the sphincter.

Wuerdemann[7] argues both ways. Under "Injuries to the Uvea from Blows":

If radial tears are seen, then atropin is contraindicated and eserin should be used to contract the pupil and draw the tears closer together.

Under "Lacerations of the Sphincter":

We would theoretically imagine that miotics would bring the torn pupillary margins together and cause healing, but such never happens. Atropin, however, is contraindicated, as its action would only tend to deepen the tear.

Under "Mydriasis and Miosis Traumatica":

If the pupil fully dilates to atropin, there has been no lesion of the dilator muscle; if contracting fully to eserin, none of the constrictor.

The accompanying illustrations show the actual size, by measurements, of pupils in three eyes before and after the use of eserin.

In the case illustrated in Figure 1, iridectomy had been done several years before for glaucoma, later extraction of the cataract was done, and still later sclerocorneal trephining, according to Elliott, all without arrest of glaucoma. In this case the tension-reducing effect of physostigmin (eserin) was demonstrated by the tonometer, which on one occasion measured the tension 39 mm. before, and 18 mm. after the use of physostigmin. That miotics can influence the tension even after iridectomy is probably generally recognized, and their use is usually advised after iridectomy.

4. Beard: Ophthalmic Surgery, Ed. 2, 1914, pp. 637, 656.
5. Bradburne: Ophthalmology, 1917, **12**, 205.
6. Bernheimer: Ophthalmology, 1914, **10**, 306 (abstr. by Zimmermann).
7. Wuerdemann: Injuries of the Eye, 1912, pp. 568, 579, 580.

In the case illustrated in Figure 2, iridectomy had been done on both eyes of a man, aged 20.

While measurements so small cannot be made with perfect accuracy, they show definitely a diminished size of the pupil and, especially significant, a narrowing of the coloboma. In both cases, and also in others, physostigmin has produced its other characteristic symptoms in addition to miosis — aching, spasmodic jerking pains, and spasm of accommodation in young persons. These symptoms, therefore, must be due to the action of the physostigmin on the ciliary body as much as to its action on the pupil. In this connection must be considered the question of the paralytic or relaxing effect of physostigmin on the dilator fibers of the iris, coincident with its spastic effect on the sphincter. In connection with the reduction of tension by physostigmin in an iridectomized eye is to be considered the mechanism of this change of tension, and the rôle in it of the ciliary body, since it evidently is not entirely due to the action of the sphincter. The conflicting opinions on the use of miotics and mydriatics in cases of injuries to the iris, especially radial tears involving the sphincter, are based mainly on theoretical considerations. It can be assumed that miotics, by diminishing the size of the pupil, can bring the margins of the tear together, and so promote healing, or that mydriatics, by relaxing the sphincter, can produce the same result. It can as reasonably be assumed that miotics, by exciting strong action of the sphincter, can pull the margins of the tear apart and so prevent healing, or even increase the tear; or that the same result can be brought about by the dilatation of the pupil produced by mydriatics. As a matter of clinical fact, however, it is probable that mydriatics and miotics have no power to increase or diminish the extent of the iris tears. Hence, the use of mydriatics or miotics is to be determined by other considerations. Usually mydriatics are indicated because of iritis, and

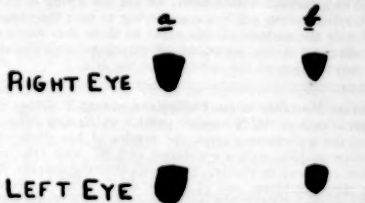

Fig. 2.—Size and shape of pupils (a) before and (b) after physostigmin.

any permanent mydriasis resulting is to be regarded as due to the injury, and not to the use of mydriatic treatment.

CONCLUSIONS

Physostigmin can produce contraction of the pupil, narrowing of the coloboma, and reduction of the glaucomatous tension in iridectomized eyes.

The contraction of the pupil and coloboma indicates that there is a relaxing effect on the radial fibers of the iris, as well as the spastic effect on the sphincter.

The action of the ciliary body is a factor in the reduction of the glaucomatous tension produced by physostigmin.

It is probable that miotics (and mydriatics) have no power to increase or diminish the extent of radial tears of the iris.

ABSTRACT OF DISCUSSION

COL. FRANK C. TODD, Minneapolis: Dr. Curdy especially relates this subject to the treatment of glaucoma, and calls attention to the fact that even where the sphincter has been cut, some contraction of the pupil takes place. It is well known that miotics, such as eserin, produce the maximum contraction of the pupil, and a maximum contraction of the pupil could not be produced unless two things take place, namely, a paralysis of the fibers that dilate the pupil, and a stimulation of the fibers—that is, of the sphincter—that contract the pupil. So it has this combined action. That is further confirmed by the fact that in the case of paralysis of the sphincter, the use of eserin will produce medium but not maximum contraction of the pupil, because it relaxes the dilator fibers. Then why should we not expect the same effect if the sphincter fibers are cut, when we have a coloboma? that is, a relaxation of the dilator fibers may take place.

This brings us to the practical point of the wisdom of producing a complete coloboma in the operation of trephining for glaucoma. I have thought that I have made some failures to permanently reduce tension where I have made too small an opening in the iris. Perhaps you remember that Elliot considered that iridectomy was of no value in his glaucoma operations, and when the iris did not present he was not in the habit of cutting the iris out. My experience has been that in some of those cases in which a sufficient amount of iris was not removed, the plugging of the hole might take place more readily afterward, and I have preferred to have a large coloboma than to have a very small one. But I do think that ideally the wide coloboma, produced with the Elliot operation, with the retention of the pupil, is more advantageous, if only for the fact that we can get more of a contraction of the pupil later by the use of a miotic, if that seems necessary. That is to say, if we can get a coloboma like this (illustrating by means of the blackboard), leaving intact the marginal fibers, we then have an opportunity to produce a maximum contraction of the pupil, if it seems wise, for after treatment to further reduce the tension.

DR. ROBERT J. CURDY, Kansas City, Mo.: It is true, as Dr. Todd says, the maximum contraction of the pupil cannot be produced if the sphincter is interrupted, but in the treatment of glaucoma with miotics, we are not trying to produce contraction of the pupil; we are trying to cure the glaucoma, and it is the purpose of this paper to show that miotics can be effective in the treatment of glaucoma notwithstanding the interruption of the sphincter of the iris.

Infant Mortality in the Philippines.—Sixto Y. Orosa, M.D., in an article in the November number of *Revista Filipina de Medicina y Farmacia* gives the results of his study of 334 families in Jolo, with a population of 8,287, with reference to infant care and mortality. He shows that the average family has three children, one of whom dies. With reference to feeding, out of 1,117, 924 were breast fed, 109 bottle fed and 84 given mixed feeding. Of the 924 children breast fed 632 lived, 68 per cent.; 292 died, 30 per cent. Of 109 bottle fed, 86 lived, or 78 per cent., and 23 died, or about 21 per cent. Of the 84 given mixed feed, 50 lived, or nearly 60 per cent., and 34 died, or 34 per cent. Thus, he says, notwithstanding the ignorance of the average mother, the percentage of deaths of those artificially fed was 21 or 22 per cent. as against 30 per cent. for the breast fed. The bottle fed also had less deaths than those given mixed feeding. Condensed milk is generally employed in artificial feeding. Out of 349 deaths, 165 occurred before the age of 1 month, or nearly 50 per cent.; 286 occurred before the child reached 5, or 82 per cent., and 336 deaths occurred before the child reached 15 years, or over 97 per cent. Infantile convulsions is among the chief and first causes of death of infants, and their mothers usually show signs of beriberi. The infant becomes blue and is seized with convulsions. The condition is called "alperesia." Intestinal diseases, malaria and respiratory diseases follow in order of importance as causes of death, and syphilis and malaria are important causes of abortion, of which there are many cases.

THE RELATION OF HEREDITARY EYE DEFECTS TO GENETICS AND EUGENICS *

LUCIEN HOWE, M.D.
BUFFALO

Of late years, while trying to learn something about ocular muscles, I have been confronted often by questions concerning heredity. I have found, as others doubtless have, three, four or even more persons in the same family with a similar form of heterophoria, heterotropia, predisposition to ocular fatigue, or similar abnormal muscular conditions. It seemed impossible to study these anomalies satisfactorily without first halting to learn something about that mystery which we call heredity.

It is understood that "genetics" is a general term including everything that pertains to generation. Heredity is more specific, dealing with "the organic relationship between generations." As defined by Davenport, "it is the phenomenon of the recurrence of traits in blood relatives due to the persistence of their determiners in the germ plasm." Eugenics refers, of course, to the improvement of a race by selected breeding.

It is not possible here to give any systematic account of the studies already made of hereditary eye defects, except to mention the classic work by Groenouw,[1] the interesting histories collected by Nettleship, the more recent bibliography by Loeb, with the exhaustive articles by him, or those by Libby and others. The point is that we ophthalmologists have been content thus far with reporting family histories without attempting to relate those histories to other facts, now well established by geneticists.

Meanwhile, the science of modern genetics has come into being and has developed rapidly, especially in its relation to defects of the eyes.

Davenport[2] includes the following conditions: degeneracy of the cornea, anomalies of iris, glaucoma, displaced lens, cataract, pigmentary degeneration of the retina, atrophy of the optic nerve, night blindness, color blindness, reduction in size of the eyeball, megalophthalmus, myopia, astigmatism, paralysis or imperfect development of the muscles of eye and lids and nystagmus.

In view of the vastness of the subject and the brevity necessary in our transactions, my objects here are to:

1. Formulate a plan by which we may relate our clinical facts to the data of genetics and eugenics.
2. Show how each ophthalmologist can contribute something to our common fund of knowledge concerning it.
3. Give the results of my own studies thus far in the form of exhibits with the presentation of the paper, and publish those results later, separately. That saves time at the meeting, and space in our transactions, but still gives credit, if any there be, to our section for priority in the work shown by the exhibits.
4. Suggest a plan which may prove practicable for preventing to some extent hereditary blindness.

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* Read before the Section on Ophthalmology at the Sixty-Ninth Annual Session of the American Medical Association, Chicago, June, 1918.

1. Groenouw, in Handbuch der gesamten Augenheilkunde, Graefe-Saemisch, Ed. 2, Part 1, 13, 415.
2. Davenport, C. B.: Heredity in Relation to Eugenics, New York, Henry Holt & Co., 1911.

The plan to attain these four objects is to:

1. Bring the bibliography to date.
2. Arrange it according to diagnoses.
3. Add new family histories of such eye defects.
4. Chart certain histories reported previously only in narrative form.
5. Compare the relation of such defects with the mendelian or other principles of heredity.
6. Show the importance of a differential diagnosis between defects really hereditary and those due to infection (syphilis).
7. Suggest a plan for the prevention of hereditary blindness by sequestration, or by sterilization if the transmitter of the blindness so elects.

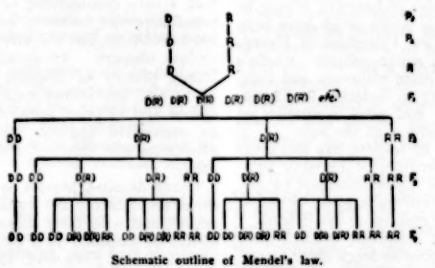
The reassuring statement should be made at once that it is not intended to cover all of this ground in this paper. For example, the first and second steps in the proposed plan are represented by what may be called Exhibit A. This is a bibliography in the form of a card catalogue. The literature up to 1901 was collected and arranged, according to diagnoses, by Groenouw. That list contained 324 references. Loeb published his bibliography in 1909, but as his list partly duplicated that of Groenouw, and was arranged alphabetically — not according to diagnosis — and as an assistant has found over 200 other real or supposed family histories of heredity, it seemed best to make a new list from 1901 and rearrange all according to diagnosis. That constitutes the present list of over 700 titles brought practically to date and arranged on a unified plan.

The third step is represented by Exhibit B. This is a group of twenty-four charts of new family histories of hereditary eye defects. These were obtained by examining the files at the Eugenics Record Office of the Carnegie Institution of Washington at Cold Spring Harbor, N. Y., and acknowledgment is here due to the director, Dr. Davenport, for the unusual opportunity thus afforded.

The fourth step is represented by Exhibit C. This is a collection of over thirty charts of hereditary eye defects. These histories were published in narrative form, and as such were difficult or almost useless for study or comparison. A few charts already published were also added to show good examples of a defect which is really hereditary and one which is not, and also to show when a defect is "dominant" or "recessive." The importance of this differentiation will appear later.

It is possible now only to mention these three exhibits. They will be explained in detail when published.

We come then to our fifth step. To state this in slightly technical terms, we ask, does a certain chart suggest in any degree the mendelian law of descent? If so, is the defect dominant or is it recessive? Or does the chart show an example of sex linkage, or are other principles of heredity involved? These are new terms to many of us, but in this paper we have to take for granted a knowledge of the wonderful law discovered by that extraordinary character, the monk, Gregor Johann Mendel, and also what that law means to students of genetics of today.



Schematic outline of Mendel's law.

THE MENDELIAN LAW

An example of mendelian descent, as demonstrated in the eyes of fowls, will recall the more important points: If one fowl having a dark red iris is mated with another that has a gray or pearl colored iris, the descendants in the first generation, called technically the first filial generation, and usually indicated F_1, will show red irises slightly mottled with pearl. That is, it happens that the red iris in poultry "dominates" almost entirely over pearl. But if members of this F_1 be bred with each other, then in the second filial generation, or F_2, we find, on counting the offspring, that about one fourth have their irises red, one fourth of them pearl, and half have mottled eyes. If the red "domination" were complete, then the proportion would be three red eyed to one pearl; but breeding tests would show that, on the average, two thirds of those with red eyes were hybrids. If now, we inbreed these F_2 individuals, we find when a red-eyed fowl is bred with a corresponding red-eyed fowl, the progeny are all red eyed, for any number of generations. Also, when the pearl-eyed fowl is bred with a pearl-eyed fowl, the progeny are all pearl eyed for any number of generations. But when two of the intermediate type in F_2 are inbred, the eyes of their progeny in F_3 are not all red, but their progeny in F_3 break up into one red, two mottled and one pearl, as in F_2. When these groups in F_3 are again inbred, we find in the succeeding generation F_4 the same behavior.

The mendelian law is usually stated briefly by letters. Thus, if we denote the dominant parent having the red iris by D, and the recessive parent having the pearl iris by R, the offspring in F_1 is indicated by D (R), the R being in parenthesis to show that it is recessive to D. The hybrid D (R) when inbred gives offspring in F_2 in the ratio, DD + D (R) + D (R) + RR. The first DD breeds true. The RR also breeds true. But each of the two intermediate D (R)'s produce in F_3 a corresponding series of DD + D (R) + D (R) + RR.

The mendelian law is also illustrated by a diagrammatic arrangement of the letters which indicate the groups of four. As none of the published diagrams seemed to make the sequence entirely clear to me at first, I have outlined the details of Mendel's law as shown in the accompanying diagram. It may also prove of assistance to other students, even if it be rather schematic.

OTHER PRINCIPLES OF HEREDITY

Sex linkage is another principle of heredity to which attention may be called. This is the tendency which certain characteristics have to develop exclusively or predominantly in the male members of the family, especially in certain crosses. For our purpose, however, it must suffice to recall the fact that among the diseases appearing predominantly or exclusively in the male line, at least in certain families, are atrophy of the optic nerve, color blindness, night blindness and probably other defects.

It is impossible in a brief statement like this to give even passing notice to other principles of heredity which are of undoubted importance in a study of eye defects. Among these may be mentioned blended and excessive inheritance, reversion, predisposition to disease, immunity, etc. But it is doubtless the case that even our present knowledge of these principles will assist us in understanding why in certain families this or that defect of the eye does appear to be dominant, and on the other hand, why in certain other families the same defect appears to be more distinctly recessive. Thus by charting the knowledge which we have thus far acquired of eye defects and comparing those charts with a knowledge of the principles of heredity, it is probable that the relation between the two will become more apparent.

APPROACH TO THE STUDY BY THE OPHTHALMOLOGIST

One of my main objects, as already stated, is to interest others, if possible, in this subject, so that they may help to solve questions that can only be hinted at here. Therefore, it is in order to indicate briefly how the study can be approached by any ophthalmologist.

As to a theoretical knowledge of heredity, it may be of assistance to mention a few books which have been found useful. Herbert's "First Principles of Heredity" gives an outline of the entire subject. Castle's "Genetics and Eugenics" is more elaborate and technical. Davenport's "Heredity in Relation to Eugenics" is especially interesting and gives a number of data relating to hereditary defects of the eye.

A short, systematic course of reading like this gives a theoretical idea of the principles of heredity sufficiently definite to enable the ophthalmologist to discern some of the relations between a given principle or line of descent and a given group of eye defects.

Theoretical knowledge is, however, second hand mental furniture. The best way to learn these principles and one vastly more interesting is to supplement the reading with at least a few experiments.

The breeding of eye defects is easier than most persons imagine. Chickens and pigeons are the best subjects for such experiments.

By advertising in the *Reliable Poultry Journal* and other trade papers, it has been possible to obtain for the parent stock more than a dozen specimens of eye defects. These included corneal irregularities, and variations in the color of the iris and in the position of the eyes and of the pupil. The different pens of chickens at a small place, known as Mendel Farm, on the lake shore near Buffalo, have proved to me a source of much interest and enlightenment.

The breeding of dogs has not been found satisfactory. Eye defects are rare, the generations slow and the litters small. For similar reasons, cats are undesirable. It is probable, however, that interesting results could be obtained by breeding white cats which have blue eyes—such cats being often deaf. This fact had been already observed by Darwin and has been the subject of breeding experiments by Dr. Graham Bell.[3]

The eyes of the small fruit fly, *Drosophila ampelophila*, have proved most interesting. I am indebted to Professor Morgan of Columbia for parent stock, the blind variety of which I bred through more than twelve generations.

3. Bell, Graham: Tr. Otol. Soc., 1885, 3, 478.

PRACTICAL VALUE OF THE STUDY

The average reader of this paper may say that such a glance at the principles of heredity may be curious and possibly interesting, but of what practical use is it?

Of course, we never find a typical mendelian ratio in the human species, because brothers and sisters never marry. But an approach to these ratios we do find constantly, and that law furnishes an important guide, not only in recognizing heredity itself in a given family history, as distinguished from an infection, but in also indicating when the defect is dominant or recessive. In other words, this relation between genetics and ophthalmology throws light on the differential diagnosis (the next step in our study), and is very decidedly practical in connection with eugenics.

With this reassurance as to the reason for continuing, let us pass to the examination of family histories to determine whether a given defect is in reality hereditary, or whether it is due to infection from syphilis or other causes.

It would necessitate a rather long digression to show just how this differential diagnosis is made. Suffice it to say that our criterion is the technical definition of heredity given at the outset. The fact is that a very considerable proportion of defects which we all supposed formerly were hereditary are probably not hereditary, but the effect of some infection more or less obscure. An excellent example of this is a family history of aniridia reported by one of the oldest and best known members[4] of this section. The author and all other ophthalmologists accepted this as an undoubted example of heredity, but competent geneticists now demonstrate that to be highly improbable.

Other diseases besides syphilis, or susceptibility to them, undoubtedly are transmitted from parent to offspring, and with these diseases we should include the effects of alcohol. In a word, caution is necessary in our diagnosis. We find, too, that even many of the muscular anomalies which seemed to be hereditary, and which prompted this whole study, are not hereditary after all.

Having thus collected various family histories, even those said to be hereditary, classified them, added to their number, charted them, studied the relation of genetics to these histories, and having seen the necessity of more exact diagnosis, we can now leave this imperfect sketch of the relation of eye defects to genetics, and pass to the eugenic aspect of the subject. The literature concerning this is scanty and confused. It will tend to clearer thinking to define a few terms. From the standpoint of eugenics, eye defects may be divided into two groups—the minor defects, or deformities, and major defects, or blindness.

The term "hereditary" we should also define more exactly as including two groups—one in which the recurrence of the defect is only "possible," especially when that defect is "recessive," the other in which its recurrence is "probable," especially when that defect is "dominant." Evidently, therefore, we have as many conditions to deal with as there are combinations, in pairs, of these four factors.

Still another factor enters into the problem—the personal equation of the parties to a marriage contract. For when two persons contemplate matrimony, it can usually be taken for granted that their judg-

4. Risley, S. D.: Hereditary Aniridia, THE JOURNAL A. M. A., April 17, 1915, p. 1310.

ment has, for the time, taken wings. Professor McCready, in his lectures at the College of Physicians and Surgeons, used to say his case records showed that for various reasons he had advised one or both parties against marriage some sixty-eight times; and his records also showed that sixty-eight times the couples went almost straight to the altar.

But temporary obsessions by those who ask an opinion is no excuse for inability to advise intelligently, or, if necessary, to restrain persons from a fatal mistake. Therefore, the other four factors in our problem demand all the more careful study. While the difference between a simple deformity and blindness is evident, it is not easy to say whether the recurrence of a given defect is "possible" or "probable." Our decision, then, must be based on three groups of data: first, whether the defect is inherited as a dominant or a recessive; second, whether it is a sex-linked characteristic, and, third, whether both families show the defect.

A few illustrations will show how these four cardinal conditions in our problem may serve as the basis for an opinion by an ophthalmologist when he is called on to give advice in the case of a proposed marriage. Thus:

A. When we have to do only with a deformity, and its reappearance is doubtful, no special objection need be raised.

B. When we have to do only with a deformity, and its reappearance is probable, the parties to the marriage should both be warned of the probability of the reappearance of that defect in their offspring.

C. When we have to do with blindness, and its reappearance is doubtful, a stricter attitude toward the union can be assumed.

D. When we have to do with blindness, and its reappearance is probable, the question assumes its most serious aspect. If the family history shows that this defect is in reality dominant, then half the children on the average will develop the defect; or even if the defect is recessive, but occurs in both families, the danger is practically the same.

Another phase of the same problem is presented when a couple is already married, and with little or no history on either side of eye defect; yet in spite of that, for reasons which we do not know, one child after another, blind or partly blind, is born to these parents. This congenital blindness is in one way quite different genetically from hereditary blindness, but from the standpoint of eugenics, families with hereditary and with congenital blindness may be considered together as one group and classed as hereditary. It is desirable to appreciate how important this group is, but space permits here only the categorical statement of a few facts, which, properly presented, would fill a small volume. These facts are:

(*a*) The number of this group in the United States is considerable. It has been estimated at about 8,000 and upward. According to the census of 1910, the total number of blind was 52,272. Counting unavoidable and admitted errors in that census, the results of subsequent surveys, and increase of population, the National Committee for the Prevention of Blindness estimated the number of blind in 1917 at from 100,000 to 110,000. According to the data given by Best in his exhaustive and recent study of the blind in this country, the proportion of hereditary and congenital blind is considerably larger than here stated. But in giving estimates, the minimum limit is evidently the safest.

(*b*) The cost also is considerable. According to statistics carefully collected in Massachusetts and elsewhere, the average cost per year of each blind person in and out of institutions is at least $475. This gives us a total annual cost of some $3,800,000.

(*c*) It is unjust to the blind to allow them to be brought into existence simply to lead miserable lives.

(*d*) It is unjust to taxpayers to be compelled to support them.

(*e*) The longer we delay action to prevent this blindness, the more difficult the problem becomes.

(*f*) A large part, if not all, of this misery and expense could be gradually eradicated by sequestration or by sterilization, if the transmitter of the defect preferred the latter. An idea of this plan is given by the somewhat similar one for dealing with feeblemindedness. In 1913, laws for sterilization, under certain circumstances, had been passed in twelve states and proposed in nine others. Bulletin 10 of the Eugenics Record Office, Cold Spring Harbor, L. I., N. Y., gives a map showing the status at that time of such legislation. Where such eugenic laws have been enacted or favorably considered, probably existing laws could be properly amended or new laws passed, to prevent this form of blindness. The same bulletin gives the form of a model law for this purpose. It was prepared by committees composed of the most eminent physicians, surgeons, sociologists, students of genetics and similar experts in this country. That law could be made applicable to the prevention of hereditary blindness, but with an important difference, which makes the prevention of this form of blindness comparatively easy and inexpensive. No legal action is essential until after a marriage has been found to produce blind children, and even then sequestration of the transmitter of the defect may be substituted for sterilization. Moreover, if this sequestration is of a kindly nature, with congenial occupations suited to the intelligence and social tastes of the subject, the sense of restraint is slight, since it is reduced to the minimum. This is not theory but experience, as shown especially by the colonies for the feebleminded established by Dr. Charles Bernstein of the State Custodial Asylum at Rome, N. Y.

WHAT ARE WE GOING TO DO ABOUT IT?

In other words, we have all this misery and expense, both of which are largely unnecessary; we have also an effective method of relief prepared by committees of our foremost experts and already well supported, in principle, by public opinion. What are we going to do about it? That is the question at last forced on ophthalmologists—especially on the Section on Ophthalmology of the American Medical Association. Shall we complacently continue to do nothing, thus retarding social advancement and even ophthalmology itself? The answer to this question involves many details, both of principle and of method, far too complicated for discussion now. But in executive session a motion will be made for the appointment of a committee to report on this subject another year. If at that time or later, some plan can be formulated for the prevention of this form of blindness, it will perhaps seem worth while for us to have directed our attention now, even in this hasty manner, to the relation of hereditary eye defects to genetics and eugenics.

ABSTRACT OF DISCUSSION

DR. HORATIO H. NEWMAN, University of Chicago: This occasion gives me an opportunity of expressing an idea that has long been at the back of my mind, that cooperation between the professional ophthalmologist and the professional genetecist might lead to far reaching results in both fields. This idea was suggested to me some years ago by a piece of genetic work which fell into my hands quite accidentally. While instructing a class in genetics at the University of Texas I dealt with night blindness as an example of one type of heredity. I made a statement that night blindness was a partially sex-limited character, appearing in every generation, but largely restricted to males.

After the class a young woman said that there was something like hereditary night-blindness in her family, but it did not follow the law stated. I found that there was quite a large family connection who were night-blind and that the defect was inherited as a sex-linked character. This led me to work out the data of optic defects for five generations of this family, which was published some years later in the *British Journal of Genetics*. The point I wish to bring out is the great difficulty that I had as a genetecist in handling that data. If I had had the cooperation of an ophthalmologist the task would have been greatly simplified. As it was I had to depend on advice kindly offered by Nettleship, advice which though meager was of the utmost value.

That, then, will bring out my point, that it would be a very valuable thing if the ophthalmologists and the genetecists could actually get together in working out some of these problems that concern these two fields.

I think I am safe in saying that nothing equals the data of ophthalmology for the study of human heredity. And particularly is that true in connection with sex-limited and sex-linked heredity. We have found in our experiments on a number of the lower animals, that some characters are inherited in a peculiar way in a sex-limited and others in a sex-linked fashion. A sex-limited character is one that is limited to the male sex, while a sex-linked character may, under certain conditions, appear in females also. The mechanism of sex-linked heredity has been worked out and may be explained by a diagram (explanation of diagram omitted). This illustrates but one of the many interesting phases of the genetics of optic defects.

DR. F. PARK LEWIS, Buffalo: Dr. Howe's paper naturally resolves itself into three distinct parts: that dealing with the mendelian law, which is a science in itself; that dealing with its application economically and socially, and the question, finally, as to what shall be done about it.

The question of the mendelian law is one of the most interesting, probably, of all topics that has come before the scientific world in a generation. Our knowledge of it dates from the beginning of the present, twentieth century, although Mendel wrote in 1881 an essay in which he demonstrated on peas the application of his law. This essay was buried in the archives of a scientific society for all the years intervening between that time and 1900, when Bateson and others, working along the same lines, brought it to the surface and found that this Austrian monk had hit on a law of heredity the importance of which can scarcely be overestimated.

Its application in ophthalmology to the development of the eye is particularly interesting, but I shall have to speak only on the economic side of it, which seems of great importance as a war measure.

The most important product now which we are raising—and we are now considering the conservation of our products—is that of our children. What is done in regard to the development of our children during the next twenty years connotes what kind of a population we shall have twenty years hence. During the last three decades there has been a very rapid decrease in the birth rate among all English speaking people, as there has been among the French, until at the beginning of the war, in 1914, the proportion had been reduced from thirty-five in a thousand in England, to about twenty. The large number of males who are taken out of active service and sent abroad will still further decrease our birth rate during these years of war.

The classes of people whose birth rate continues high as a rule are those who live under the most unsanitary conditions. In the Polish population, where it is very crowded, the average number of members in a family is eight. In what we call the better classes of people, those who are more intelligent, the average number of children in a family is but three. It has been found that where people live in four room tenement houses, the number of children who live is about thirty-five in a thousand. Where they live in three room tenement houses the proportion is about thirty in a thousand. Where they live in one room tenement houses, the number who live is still further reduced. So that the housing problem means that we are losing the productive element in our population in very large proportion, just to the degree that we decrease the sanitary conditions under which they live.

Moreover, where defects of any kind exist, such as feeblemindedness, defects in vision or other characteristics, the grouping of people together is very apt to make those who are sufficiently closely related to have the same traits, and the possibility of perpetuating those traits, brought together, so that they are apt to marry. It happens that during the last twenty-five years I have been connected with the School for the Blind, and I have seen during those years the effect of the perpetuation of the defects of blindness in the most remarkable degree. Four generations ago two congenitally blind people married. The progeny, the result of that marriage, have been coming back to the school during those twenty-five years, until we have now had from one family, seventeen, and from another family of cousins, seventeen. Without going into the details of the economics involved, I may say that single marriage has cost the state of New York more than $50,000 for the education and maintenance of all of these blind people.

I was interested in the case of the prevention of ophthalmia neonatorum, because of the multitude of cases that I found in the School for the Blind who were blind as the result of birth infection. The number of children that are blind as the result of congenital atrophy was greater, and always has been greater than that resulting from ophthalmia neonatorum.

DR. CLARENCE LOEB, Chicago: Assuming the correctness of the mendelian theory, we must remember that it was worked out with plants and animals, where there is more than one offspring of a single mating. In man, however, a single mating, as a rule, results in one offspring, seldom two and very infrequently three or more. I do not see that it necessarily follows that the facts in the former case, that is, where there are more than one offspring at a birth, are true in a case in which there is only one. But granting that the facts will be the same, the theory further demands that two of the same generation must mate, which never takes place in man under present circumstances. Formerly, and in the far dim past, brothers and sisters would mate, but at the present time this never takes place.

How can we assume that the mating of two strains, as in the case of the marriage of two blind, unrelated people, will have the same effect as the joining of two strains from the same source? As a matter of fact, the histories of the cases in which two blind parents, whether related or not, marry, show that the percentage of their children was no greater than when one blind and one seeing person married. Furthermore, the mating of the red sweet pea for example, with the white sweet pea, is the mating of normal characteristics, while the mating of a blind with a seeing person, for instance, a cataractous person with a seeing person, is the mating of a normal with a pathologic condition. How do we know that the theory will work out under those circumstances?

The histories of these cases show that it does not, as the percentage of children affected, whether there was more than one child from one family or not, ranges anywhere from 100 per cent to no per cent.; that is, all the children, to none of the children. There is no definite rule that can be followed. Take up a history and you are as likely to find all the children of such a marriage become blind as only one or none.

It is always possible for a theory to have exceptions, but where a theory such as Mendel's theory is applied to the inheritance of ocular conditions—and that is all I am speaking of; I am not talking about that theory as a whole—and you have so many exceptions, as the history of all the cases shows, I must say that I do not see that the mendelian theory can be applied, and that we can assume from that what the results will be as to the offspring. The only thing I can see is to collect as many cases as possible of the results of such a marriage, and from the number of children calculate what percentage is likely to become involved. If the mendelian theory were true as far as man is concerned, then as Dr. Howe suggests, instead of sterilizing the person, it would seem to me the thing to do is to allow a person who is affected to marry and then find out from his offspring which marry the ones who propagate the diseased condition, and sterilize them or prevent them from marrying and allow the other strains to continue to marry and have children.

DR. F. G. STUEBER, Lima, Ohio: It was Dr. Wiley who made the statement, that as a people, we have been giving too much attention to the breeding and raising of hogs, rather than to that of our children; but he thought that mankind should come next. Not to underestimate the other papers I regard this as one of the most important subjects, and believe it is the duty of every normal individual to contribute what he can for the betterment of the race. It is said, every child has the right to be well born, and I think it devolves on the profession and the press to enlighten the masses, the laity, believing that they will be ready to take that counsel and heed the advice.

DR. LUCIEN HOWE, Buffalo: I do not know of any brief statement more conclusive than the family histories of the pupils at the School for the Blind at Batavia, N. Y., as given by Dr. Lewis. They show the desirability of some action for the prevention of hereditary blindness.

As for objections to the mendelian theory raised by Dr. Loeb, that is for geneticists to decide. The fact is, however, that opportunities do occur for the breeding among human beings of eye conditions. For example, when one of a Northern race, from Ireland or Scandinavia, marries an Italian, we can observe the eye colors of the hybrids, and if first cousins of such crossings marry, the results can be followed in the second generation. In a similar manner opportunities are afforded occasionally for tracing serious eye defects. As fas as we know, these abnormal conditions follow the same mendelian law as do other conditions which we call normal.

Through the kindness of Professor Morgan and Dr. Bridges of Columbia University, I have been furnished with stock colonies of an insect now a classic subject for experiment. The specimens with deformed eyes and the eyeless variety I have bred through a considerable number of generations. Live specimens are presented in bottles for examination.

Finally, I ought to say that I did not make personally the bibliography or the new charts from the old family histories. The work was simply supervised in my office, by my wife and my secretary, and by the secretary of the editor of the bibliography in the *American Journal of Ophthalmology*.

Follow-Up Medical Inspection.—There is a strange lack of logic in the way we take care of our industrial children as compared with our schoolchildren. Medical inspection of schoolchildren has attained a place of considerable prominence in our child welfare problems, and we have almost come to regard as beyond the pale the school district so benighted that it pays no attention to the health of its schoolchildren. . . . All sorts of safeguards have been thrown around employed children in the shape of age limits below which they may not be employed, regulation of hours, elimination from obviously dangerous occupations, such as mining—all of which undoubtedly have their part in preventing injury to the health of undeveloped children. But the physical safeguards considered indispensable up to the moment the child begins work are not heard of after the doors of industry are closed behind him.—Florence I. Taylor, *Child Labor Bulletin*, February, 1918.

Clinical Notes, Suggestions, and New Instruments

CULTIVATION OF THE MENINGOCOCCUS UNDER PARTIAL OXYGEN TENSION

A POSSIBLE EXPLANATION OF THE POOR SUCCESS OF THE USUAL CULTURAL METHODS*

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A method by which meningococcus cultures may be easily obtained in sufficient quantity for rapid agglutination has long been sought. Almost every bacteriologist has some special medium on which he relies. In many camps, primary isolation is attempted on some solid medium, such as rabbit's blood agar or sheep serum agar; in others, various liquid mediums are used.

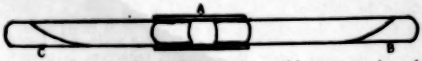

Fig. 1.—Apparatus for incubating under partial oxygen tension: *A*, rubber tube; *B*, tube with B. subtilis culture; *C*, tube with spinal fluid culture.

At this hospital it had been customary to make primary isolations from spinal fluid on solid mediums. When large amounts of fluid containing many organisms were planted, this method usually yielded a few colonies which had to be nursed along through several subcultures before rich growth was obtained. Only too often the culture was lost. Finally an enriched broth was used. A mass culture was made by pouring from 8 to 10 c.c. of spinal fluid into 100 c.c. of human serum glucose infusion broth. Usually within twenty-four hours a good growth was obtained; but when transplants were made from this broth to solid mediums, growth was meager or entirely absent. Frequent transplants had to be made to insure good growth, and many cultures were lost.[1]

It occurred to me that the explanation of this phenomenon was to be found in the fact, to which attention had previously been called,[2] that the meningococcus is a micro-aerophil, and

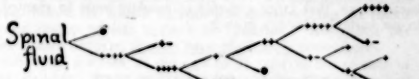

Fig. 2.—Adaptation of the meningococcus to changes in oxygen tension: Upstrokes, aerobic cultures; downstrokes, partial tension cultures; +−, doubtful growth; ++++, very rich growth.

that only a few individuals are sufficiently facultative to grow under aerobic conditions. To test this idea, the following method was adopted:

Each specimen of spinal fluid was divided into two parts. One portion was poured into a bottle of glucose infusion broth; the other was centrifuged, and a loopful of the sediment was planted on each of two slants of human serum glucose infusion agar. One slant was incubated aerobically; the other was placed under partial oxygen tension by connecting the slant to a freshly inoculated agar slant of *B. subtilis* by means of rubber tubing (Fig. 1).

Confluent growth over the whole surface of the slant was usually obtained in the partial tension cultures, while only one or two scattered colonies could be found on the aerobic slant if there was any growth at all. The broth cultures grew well; most of the growth was found near the bottom of the 100 c.c. bottle that was used. Aerobic and partial tension

* From the laboratory of the base hospital, Camp Lee, Va.

1. Asnis, E. J.: Personal communication to the author.
2. Cohen, M. B., and Markle, Louis: A Method Which Greatly Facilitates the Culture of the Meningococcus, THE JOURNAL A. M. A., Oct. 28, 1916, p. 1302.

transplants were made from each broth culture; partial tension growth was always rich, aerobic growth was always scant.

Figure 2 shows in graphic form the approximate adaptation of the meningococcus to changes in oxygen tension. Doubtful growth is indicated by +—; very rich growth by + + + +. The upstrokes indicate aerobic cultures, the downstrokes partial tension cultures. This chart makes these three points very clear:

1. Much better growth in primary cultures is obtained under partial tension conditions.

2. It is quite difficult to get aerobic strains from partial tension ones.

3. Aerobic strains when split off from partial tension ones have a tendency to remain aerobic, and do not grow at all well in lower pressures of oxygen.

For the isolation of meningococci from mixed cultures or from the nasopharynx, a very simple method of partial tension plating has been used.[3] It consists briefly of two notched Petri dishes inverted over a glass tube on a glass plate and sealed to the plate with wax (Fig. 3). In one Petri dish is placed the material to be cultivated; in the other, a freshly made culture of *B. subtilis*. As this method is impracticable for meningococcus carrier work on a large scale, it is hoped that in the near future the optimum reduction in oxygen tension necessary for meningococcus culture will be measured and that simple and practical methods for such culture will be worked out.

Fig. 3.—Apparatus for partial tension plating: *A*, *A*, inverted Petri dishes; *B*, glass tube; *C*, glass plate.

CONCLUSIONS

1. The meningococcus is a micro-aerophil, and partial oxygen tension methods of culture should be adopted for its isolation.

2. Relatively few meningococci are capable of aerobic growth. The growth ordinarily obtained by aerobic methods of culture consists of those organisms, which constitute the small minority of meningococci, that are capable of adaptation to full oxygen tension. This explains the statements made by many authorities, and found in many standard works on bacteriology, that large amounts of exudate must be planted to get suitable primary growth.

THE BLOOD PRESSURE IN GOUT

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The literature contains few data on the blood pressure in gout. It is reasonably well established that certain of the purin bases are hypersensitive in action. Desgrez and Dorléans' have shown experimentally that the injection of xanthin and of uric acid causes an increase of blood pressure. It is generally understood that in gout a high pressure is the rule with increasing hypertension during the acute attacks (pain), and in the later stages hypotension develops associated with cachexia, acidosis and cardiac weakness. The hypertension is supposed to be of some value in distinguishing between lesions of the joints, the skin and the eye, as to whether they are tuberculous or gouty in origin, on account of the fact that in tuberculosis the blood pressure is usually low.

In the past ten years I have carried out frequent blood pressure readings on four patients with classical gout, all subject to acute attacks of gout, and the results are of some interest.

The accompanying table presents the data obtained in this study.

BLOOD PRESSURE OBSERVATIONS ON FOUR PATIENTS WITH GOUT

Case No.	Year	Month	Age	Systolic Pressure	Diastolic Pressure	Clinical Findings
1	1908	2	42	130	100	No acute symptoms
	1909	3	43	140	100	No acute symptoms
	1910	1	44	150	100	Acute attacks
	1910	8	44	130	100	No acute symptoms
	1911	2	45	135	90	No acute symptoms
	1911	12	45	135	100	No acute symptoms
	1912	2	46	135	100	No acute symptoms
	1913	1	47	200	100	Acute attack
	1914	1	48	140	100	No acute symptoms
	1915	2	49	140	100	No acute symptoms
	1915	11	49	195	100	Acute attack
	1916	3	50	135	90	No acute symptoms
	1916	10	50	140	90	No acute symptoms
	1917	2	51	210	110	Acute attack
	1917	8	51	130	100	No acute symptoms
2	1910	1	44	170	90	No acute symptoms
	1910	8	44	195	100	Acute attack
	1911	2	45	130	90	No acute symptoms
	1911	10	45	130	90	No acute symptoms
	1912	3	46	120	80	No acute symptoms
	1913	4	47	215	100	Acute attack
	1914	2	48	130	90	No acute symptoms
	1915	1	49	120	85	No acute symptoms
	1915	10	49	120	80	No acute symptoms
	1916	2	50	210	100	Acute attack
	1917	1	51	130	90	No acute symptoms
	1917	11	51	220	110	Acute attack
	1918	2	52	120	80	No acute symptoms
3	1913	2	58	220	110	Acute attack
	1914	1	59	120	90	No acute symptoms
	1915	2	60	220	110	Acute attack
	1916	4	61	110	80	No acute symptoms
	1916	12	61	115	80	No acute symptoms
	1917	3	62	220	110	Acute attack
	1917	12	62	110	80	No acute symptoms
4	1913	2	60	240	120	Acute attack
	1914	1	61	110	80	No acute symptoms
	1915	1	62	110	70	No acute symptoms
	1916	2	63	230	110	Acute attack
	1917	1	64	240	120	Acute attack
	1917	10	64	110	80	No acute symptoms

A study of this table shows clearly that hypertension was not present in the cases of gout studied, except during the presence of an acute attack of gout. Between attacks the blood pressure tended to be lower rather than higher than the normal.

Jenkins Arcade.

FURTHER STUDIES ON THE PRESERVATION OF COMPLEMENT BY SODIUM ACETATE

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Captain, M. R. C., U. S. Army
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Sufficient time has now elapsed to convince all serologists, who have investigated the preservative properties of sodium acetate on guinea-pig complement,[1] of its value. Since Army service has interrupted my studies, I desire to submit my present data in order that investigators who have the facilities may, if so inclined, work out the interesting problems indicated. It is hardly necessary to state that any step which makes for stability and simplification of laboratory technic, no matter how simple, may, in its application, be of tremendous value. One of the greatest complications to the Wassermann technic was the unstability of complement, and it occurred to me that if anything could be found to stabilize this very essential component it would be of considerable value. I therefore set about systematically to test the chemicals at hand in my laboratory for their respective effect on blood, with particular reference to complement, and their effect on the Wassermann reaction.

Three agents were found which did not interfere with the Wassermann reaction, which had no hemolytic properties, which did not prevent hemolysis and, therefore, did not destroy complement. They were: (1) sodium acetate, C. P. (in any strength); (2) camphor crystals, and (3) 0.5 per cent. phenol (carbolic acid).

3. Cohen, M. B.: A Simple and Reliable Method of Making Partial Tension Plates, The Journal A. M. A., Jan. 12, 1918, p. 84.

1. Desgrez and Dorléans: Compt. rend Acad. d. sc., 1913, **156**, 93.

1. Rhamy, B. W.: Preservation of Complement: A Preliminary Report, The Journal A. M. A., Sept. 22, 1917, p. 793.

The solutions of sodium acetate and of 0.5 per cent. phenol were made up in physiologic sodium chlorid solution (0.85 per cent.) in distilled water. I have not as yet determined whether 0.5 per cent. phenol or camphor crystals will preserve complement or, if so, whether either would act better than sodium acetate. It has been shown that a minute crystal of camphor will, by inhibiting germ growth, preserve amboceptor and stabilize its unit of strength. In passing I desire to recommend the formaldehyd method for preserving red cells.[2]

Ordinarily red cells kept in physiologic sodium chlorid solution in the refrigerator will begin to hemolyze in about forty-eight hours. When the formaldehyd solution (1.25 c.c. solution of formaldehyd in 1,000 c.c. physiologic sodium chlorid solution) is used, hemolysis begins in about a week. The formaldehyd must be washed out before use, as it is anticomplementary. My procedure is to take the human cells left on separating patient's serum, cover them without washing with about five volumes of the formaldehyd solution, and keep in an ice box. They are washed when needed.

For the preservation of complement I have found that sodium acetate is ideal. It has the following properties:

(*a*) It has no hemolytic action.

(*b*) It is not anticomplementary.

(*c*) The solution can be sterilized.

(*d*) Dissolved in physiologic sodium chlorid solution, it has the same hydrogen ion concentration as blood P_H 7.4.

(*e*) It preserves and stabilizes complement from two to three months in the ice box, or two weeks at room temperature.

(*f*) It can be used in any strength from 5 to 50 per cent. or in crystal form.

(*g*) Its preservative properties are not antibacterial, and therefore must be physicochemical.

(*h*) Added to whole blood in certain strengths, it prevents coagulation.

(*i*) It will preserve human complement.[3]

In preparing complement, it is best to sever the neck arteries of the guinea-pig and obtain all the blood. As soon as the clot is well formed, it is broken up gently and centrifugalized. The serum is pipetted off and a 40 per cent. dilution of all the serum immediately made with 12 per cent. sodium acetate solution, thus preserving the full complementary strength. Placed in the ice box, it will keep until the whole amount is used up. In this dilution the final concentration of acetate is two thirds of 12, or 8 per cent.

From 10 to 12 per cent. stock solutions of sodium acetate work best for the following reasons: Sodium acetate has weak bactericidal power, so that a 50 per cent. solution keeps the serum clearer than does a 5 per cent. solution. If the serum diluted with a 5 per cent. sodium acetate solution is contaminated, it spoils rapidly, losing its complementary activity in four weeks or less in the ice box. On the other hand, although the 50 per cent. acetate solution prevents germ growth except mold, there comes a time, usually in about three weeks, when this complement solution suddenly becomes inert. (Fifty per cent. or saturated sodium acetate solution added to serum to make a 40 per cent. dilution causes a slight crystalline precipitate, the supernatant fluid containing the complement.) Using from 10 to 12 per cent. sodium acetate solution as the diluent and making a 40 per cent. dilution of the guinea-pig serum is the ideal. Such a complement solution prepared sterilely has retained its complementary activity as long as three months in the refrigerator and for two weeks at room temperature in a sunlit window in August. The loss in unit strength is gradual, about 0.02 per week. For example, a 40 per cent. acetate complement dilution, the Wassermann unit of which would be 0.1 c.c., would probably be 0.125 the second week and 0.15 the third or fourth week.

On account of the variability in hemolytic resistance of red cells,[4] it is necessary to retitrate this complement dilution each time a new batch of cells is used. If used in this manner, sodium acetate has no deleterious effect on the Wassermann reaction. Indeed, if anything, the reactions are clearer cut with its use. In the 12 per cent. acetate complement dilution, germ growth occurs when contaminated; but my experience has been that this does not affect the complementary activity. I have many times used such a complement cloudy with bacterial growth but with comparatively strong complement unit. Further the addition of 10 per cent. Sodium Acetate to Culture Media (Dextrose agar) did not inhibit the growth of Streptococci. It is obvious, therefore, that the action by which acetate preserves complement must be in some way a physicochemical phenomenon, that is, that complement enters into a loose combination with sodium acetate.

This opens a very interesting and fertile field for investigation as to the nature of this elusive labile substance called complement, and suggests the possibility that it is an enzyme with definite chemical composition. As to the property sodium acetate has, as I have found, of preventing coagulation and at the same time not destroying complement, it may be that it would be of more value in blood transfusion than sodium citrate, which does destroy complement. It would therefore be of value to determine its toxicity, the minimum amount necessary to prevent coagulation, and whether or not the presence of complement makes blood more suitable for transfusion.

2. Jour. Lab. and Clin. Med., 1917. (Reimamann, Vol. 2, p. 200.) (The preservation of erythrocytes for the Wassermann reaction.)

3. Noguchi, Hideyo: A Method of Facilitating the Serum Diagnosis of Syphilis Under War Conditions, THE JOURNAL A. M. A., April 27, 1918, p. 1252.

4. Rhamy, B. W.: Variations in Resistance of Blood Cells to Hemolysis, THE JOURNAL A. M. A., Nov. 17, 1917, p. 1728.

CHRONICALLY ENLARGED SPLEEN (MALARIAL?)

J. C. VANNUYS, M.D., LUFKIN, TEXAS, AND M. B. STOKES, M.D., HOUSTON, TEXAS

Mrs. B. T., aged 34, was one of fourteen children, ten of whom, five boys and five girls, lived to be grown. Three sisters and four brothers are now living. The father died of dysentery at the age of 68. The mother is still living, aged 68.

At the age of 10 years the patient had had a prolonged attack of fever, during which the spleen had become enlarged and dislocated downward. During this attack of fever, she had had severe constipation. Since the attack she has had many similar ones, each being accompanied by an enlargement of the spleen. Each time, after the subsidence of the temperature, the splenic enlargement decreased, but the tumor could always be felt in the hypochondrium. Ever since her first attack of fever, she has been obstinately constipated.

She was married at the age of 21, and is the mother of six children, three boys and three girls, all healthy and robust. Her husband has been dead a year. She has been in bad health her entire married life, being always worse, if not practically helpless, during her periods of gestation. During each pregnancy, she suffered severely with nausea, and pain in the left side of the abdomen.

Dr. VanNuys was called to see her, Nov. 5, 1911. The patient had been seized the night before with severe cramplike pain in the abdomen, and diarrhea. From this time until December 7, the date of the operation, she had many attacks of severe pain in the abdomen, which were cramplike in character, each attack leaving the abdomen increasingly tender. Her temperature ranged from 99.2 to 100.2 F. She persistently refused the advice of her physician, that an exploratory operation be performed.

During a lull between attacks, a bimanual examination was made by Drs. VanNuys and Bledsoe. This examination revealed the facts that all the pelvic landmarks were obliterated, and that the uterus was firmly fixed.

About December 1, she finally consented to an operation and was brought to Houston. On her entrance into the hospital her condition was very poor. After she had had a few days of rest, we felt justified in proceeding with the operation.

When the abdomen was opened a large reddish purple tumor mass was revealed, plastered over by many adhesions involving the omentum, intestine and pelvic organs. After the tumor mass had been freed from the surrounding viscera, something of its character and origin was determined. It had the appearance and physical characteristics of a cyst. A large trocar was thrust into the tumor, but the capsule was so friable that it split in many directions, allowing a thick reddish purple fluid to pour out. Further dissection revealed the fact that the tumor mass was the remains of a large spleen, the pedicle of which had become twisted, shutting off the circulation and resulting in moist gangrene of the organ.

The pedicle was ligated, as much of the tumor was removed as was possible, cigaret drainage was instituted, and the abdomen was closed. The patient's general condition was very bad when she left the table.

Microscopic examination of some of the less necrotic pieces of the tumor was made by Dr. Martha Wood, corroborating the operative diagnosis.

After three stormy days, the patient began to rally, and was able to leave the hospital and to return to her home for Christmas, although the wound continued to drain freely until January 30, since which time she has been perfectly well.

COMMENT

The location of the patient's home in a district of Texas, notorious at the time of her girlhood for the prevalence of malaria, in addition to the diagnosis of malaria given to the patient by the family physician who saw her during her first attack, leads us to the assumption that the primary enlargement of the spleen was malarial in origin.

An Error of the Wassermann Test.—A test that I have used has proved many negative results to be positive. I perform the Wassermann test exactly the same as the original test, using the four hour ice-box incubation. There is an adjustment in the use of the amboceptor. Some technicians employ twice the smallest degree of amboceptor used in the titration that produces hemolysis. Others employ as high as three and four times the smallest degree of amboceptor as a unit. Using a larger amount than the titration allows gives more negative results, some of which prove to be positive. I wish to emphasize the fact of using the smallest degree of amboceptor as a unit, along with twice the smallest degree as a unit. Cases that are negative with twice the smallest degree as a unit and are + + + + with the smallest degree as a unit should be recorded as + + + +, provided, of course, the test control and the known serum show complete hemolysis. Accordingly, any cases that show + +, + + + or + + + + are to be recorded as such. Doubtful reactions are to be excluded. My results have been very satisfactory. I have found many + + + + reactions that were reported to me as negative by reliable laboratories, and my results have proved to be correct. Once more I urge that the smallest degree of amboceptor as a unit be used with twice the smallest degree as a unit. Many well known technicians have stated that the reactions with the smallest degree of amboceptor as a unit have proved not to be "snappy." However, sometimes reactions occur that are too "snappy," which might prove to be positive if the smallest degree of amboceptor as a unit was used also. Many errors in diagnosis are made because of a false Wassermann report.—EMANUEL JACOBSON, Brooklyn.

Health Insurance.—Today, for example, we possess a mighty power to fight disease. To the wealthy class this scientific knowledge is available; to the poverty-stricken it is doled out in charity dispensaries. But for the masses of the working population—in the United States alone among the great industrial nations—such treatment is not available. Through a properly organized system of health insurance it would be possible to bring the world of medical science to the aid of the humblest wage earner.—John B. Andrews, *The Survey.*

Military Medicine and Surgery

THE EYES OF THE ARMY*

ALLEN GREENWOOD, M.D.
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BOSTON

When an ophthalmologist studies the new regulations for drafted and enlisted men, he is immediately confronted with the fact that men with low vision, which can be raised by glasses to the required standard in one eye, are enrolled for some form of limited military service, and at once the thought comes, How are these men to be supplied with glasses if they have none, and how are lost or broken glasses to be replaced here, and overseas?

The problems are more easily solved for this country than for abroad; but to obtain the best solution, the work here and there must be coordinated. In the early days following our country's entrance into the arena of world conflict, the Subcommittee on Ophthalmology of the General Medical Board of the Council of National Defense took up these problems, which then, owing to a higher standard of visual requirements, were less difficult than at present, and a plan was worked out for adopting a standard type of frame for all soldiers, and for the establishing of a small optical shop to be connected with a special hospital for surgery of the head to be sent overseas.

Various types of frames were experimented with and the following specifications finally adopted:

White metal, best stiff construction; 40 mm. round eye; special 0.055 inch full length cable temple 6½ inches; split joint end piece; 0.072 eye wire.

Bridges assorted as follows: 8/12 of N1 ½ long shank; 3/12 of N1 long shank; 1/12 of N1 ½ regular.

When the members of the subcommittee were commissioned in the Medical Reserve Corps, these plans were enlarged and modified to fit new conditions, and carried into effect by the ophthalmic department of the Division of Surgery of the Head in the Surgeon-General's Office.

Some of the ophthalmologists in this country have criticized the standard frames adopted, and with justice, for it would be impossible to select any type of frame that could not be criticized. The frame adopted, however, with its three variations of bridge, seemed to those studying this phase of the problem to present the fewest faults. The criticism was several times presented by ophthalmologists that the three types of bridge did not allow for enough variations; but before adopting such, a set of these frames was given to several first-class adjusting opticians, who quickly demonstrated that any fit likely to be called for could be obtained from one of the three bridges. It is true that the bridges are stiff, but this disadvantage is more than balanced by the fact that, once properly adjusted by the skilled mechanic, they are likely to remain in place. The criticism, however, most frequently sent in pertains to the round eye piece, and the disadvantage that the cylindric lenses may be turned in the frames. This complaint is best answered by calling attention to the fact that all cylindric lenses when in place will be marked in the side at a point close to the

* Read before the Section on Ophthalmology at the Sixty-Ninth Annual Session of the American Medical Association, Chicago, June, 1918.

middle of the temple attachment, and this pointed out to the soldier so that he can watch for any possible shifting. If experience proves that the rim cannot be tightened sufficiently to prevent the slipping round of the lens, then it is a simple matter for the optician to

TABLE 1.—BENCH OUTFIT FOR EACH OF THE MOBILE UNITS

Solder slate	Pens and holders
Blow pipe	Protractor
Silver solder	Screw taps
Soft solder	Millimeter gage
Borax	Ajax wrench
Assorted files	Millimeter rules
Screw drivers	Lens washers
Assorted pliers	Soft solder acid
Hand drill	Camels hair brushes
Assorted screws	Reamers
Rubum	Spring punch
Alcohol lamp	Temple washers
Emery cloth	Solder burrs
Chamois strips	Hand burr machine
Assorted dowels	Solder tweezers
Lens measure	Drills Nos. 59 and 67
Hammer	Guard rivets
Anvil	Zylonite blades
Neutralizing set	Temple tubing
Marking ink	Cork nose rests
Marking pencil	Oil stove

3 gross service frames (1 gross each of 3 bridges)

put a tiny bit of solder on the inner groove of the eye piece, and notch the lens at the proper point to fit this little projection. The critics have advocated an oval lens; but to see the tremendous disadvantage of this, one has but to consider the millions of extra

TABLE 2.—LENSES, EDGED TO FIT SERVICE FRAMES

3 dozen pairs	+ .25 sph.
3 dozen pairs	+ .50 sph.
3 dozen pairs	+ .75 sph.
3 dozen pairs	+1.00 sph.
3 dozen pairs	+1.25 sph.
3 dozen pairs	+1.50 sph.
3 dozen pairs	+1.75 sph.
3 dozen pairs	+2.00 sph.
3 dozen pairs	+2.25 sph.
3 dozen pairs	+2.50 sph.
1 dozen pairs	+2.75 sph.
1 dozen pairs	+3.00 sph.
1 dozen pairs	+3.25 sph.
1 dozen pairs	+3.50 sph.
½ dozen pairs	+4.00 sph.
½ dozen pairs	+4.50 sph.
½ dozen pairs	+5.00 sph.
3 dozen pairs	— .25 sph.
3 dozen pairs	— .50 sph.
3 dozen pairs	— .75 sph.
3 dozen pairs	—1.00 sph.
3 dozen pairs	—1.25 sph.
3 dozen pairs	—1.50 sph.
3 dozen pairs	—1.75 sph.
3 dozen pairs	—2.00 sph.
3 dozen pairs	—2.25 sph.
3 dozen pairs	—2.50 sph.
1 dozen pairs	—2.75 sph.
1 dozen pairs	—3.25 sph.
1 dozen pairs	—3.50 sph.
½ dozen pairs	—4.00 sph.
½ dozen pairs	—4.50 sph.
½ dozen pairs	—5.00 sph.
1 dozen pairs	+ .25 cyl.
1 dozen pairs	+ .50 cyl.
1 dozen pairs	+ .75 cyl.
1 dozen pairs	+1.00 cyl.
½ dozen pairs	+1.25 cyl.
½ dozen pairs	+1.50 cyl.
½ dozen pairs	+1.75 cyl.
½ dozen pairs	+2.00 cyl.
1 dozen pairs	— .25 cyl.
1 dozen pairs	— .50 cyl.
1 dozen pairs	— .75 cyl.
1 dozen pairs	—1.00 cyl.
½ dozen pairs	—1.25 cyl.
½ dozen pairs	—1.50 cyl.
½ dozen pairs	—1.75 cyl.
½ dozen pairs	—2.00 cyl.

cylinders and spherocylinders cut and edged that the optical units sent abroad would have to carry to meet all the degrees of axes called for, if frames with oval eye pieces had been adopted.

It has been decided by the Surgeon-General's Office to supply all soldiers and noncommissioned officers in this country and abroad with the glasses required. For the men in the cantonments, arrangements have been made whereby the prescription of the ophthalmic medical officers can be filled through the post exchanges and the Medical Supply Depot.

Steps were taken to have a first-class optician assigned to the special building in the various cantonments and base hospitals to assist in the adjustment of frames supplied to the soldiers through the exchanges. Many first-class opticians have been drafted or taken into the service, so that it was not difficult for the division surgeon in the various cantonments to find a qualified optician for this position.

Early in February, I received a cablegram, which had been sent by General Pershing, calling for optical units for overseas service to consist of a central optical shop, with surface grinding machines, and eight auxiliary units to establish optical centers in various locations in France. Capt. F. H. Edmonds, the Washington optician, was secured for the position of commanding officer of the units, and thirty-five

TABLE 3.—SPHEROCYLINDERS, ONE-HALF DOZEN PAIRS EACH

+ .25+ .25	+ .25+ .50	+ .25+ .75
+ .50+ .25	+ .50+ .50	+ .50+ .75
+ .75+ .25	+ .75+ .50	+ .75+ .75
+1.00+ .25	+1.00+ .50	+1.00+ .75
+1.25+ .25	+1.25+ .50	+1.25+ .75
+1.50+ .25	+1.50+ .50	+1.50+ .75
+1.75+ .25	+1.75+ .50	+1.75+ .75
+2.00+ .25	+2.00+ .50	+2.00+ .75
+ .25+1.00	+ .25+1.25	+ .25+1.50
+ .50+1.00	+ .50+1.25	+ .50+1.50
+ .75+1.00	+ .75+1.25	+ .75+1.50
+1.00+1.00	+1.00+1.25	+1.00+1.50
+1.25+1.00	+1.25+1.25	+1.25+1.50
+1.50+1.00	+1.50+1.25	+1.50+1.50
+1.75+1.00	+1.75+1.25	+1.75+1.50
+2.00+1.00	+2.00+1.25	+2.00+1.50
— .25— .25	— .25— .50	— .25— .75
— .50— .25	— .50— .50	— .50— .75
— .75— .25	— .75— .50	— .75— .75
—1.00— .25	—1.00— .50	—1.00— .75
—1.25— .25	—1.25— .50	—1.25— .75
—1.50— .25	—1.50— .50	—1.50— .75
—1.75— .25	—1.75— .50	—1.75— .75
—2.00— .25	—2.00— .50	—2.00— .75
— .25—1.00	— .25—1.25	— .25—1.50
— .50—1.00	— .50—1.25	— .50—1.50
— .75—1.00	— .75—1.25	— .75—1.50
—1.00—1.00	—1.00—1.25	—1.00—1.50
—1.25—1.00	—1.25—1.25	—1.25—1.50
—1.50—1.00	—1.50—1.25	—1.50—1.50
—1.75—1.00	—1.75—1.25	—1.75—1.50
—2.00—1.00	—2.00—1.25	—2.00—1.50

other first-class mechanical opticians were secured, mostly by induction into the service of registrants from different parts of the country, who were highly recommended as skilled grinders, edgers, mounters and adjusters.

Each one of the auxiliary units was provided with a full equipment of cut and edged lenses, and supplied with frames and a kit of all tools necessary for the work of putting proper glasses into the frames, adjusting the latter, and repairing any frames that might be broken or otherwise injured. It was found that all of these supplies for each auxiliary unit could be packed in three of the regulation service suit cases, thus simplifying the transportation problem. A list of supplies issued a single unit is given in the accompanying tables. Lenses of strengths not included can be obtained on order from the central shop.

For the central optical unit, a full equipment of machinery for the surfacing and edging of lenses, together with a plentiful supply of glass and blanks,

was provided. Electric motors, with all necessary belting and shafting, were, of course, included, the plan being to establish in some central location a manufacturing plant that could turn out from 150 to 200 pairs of lenses a day, and also take care of all repair work that would be likely to come in. All of the cut and edged lenses furnished for the auxiliary units, together with the equipment and machinery, were furnished by the American Optical Company of Southbridge, Mass., on record time, though this required their working nights, days and Sundays on the basis of eight hour shifts.

With this equipment and the skilled groups of men sent over, it should be possible to take care of the optical work in France with a high degree of efficiency. This is all made necessary by the fact that it is impossible to get this work done in the French shops. It is the expectation of the Surgeon-General's Office that future contingencies, as they arise along this line, can be properly cared for by enlargement of the present optical units.

OPTIC ATROPHY AND MULTIPLE PERIPHERAL NEURITIS

DEVELOPED IN THE MANUFACTURE OF EXPLOSIVES (BINITROTOLUENE)

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The great increase in the last three years in the demand for powerful explosives has not only enormously increased the number of employes in munition plants but also has doubtless added many workers who from lack of skill or from carelessness have rendered themselves more susceptible to the poisonous substances handled than would be the case with older and more experienced workers. At any rate, a large number of instances of industrial poisoning has appeared recently in such plants and a considerable literature bearing on the subject has appeared in Europe, and to a less extent in this country. Especially to be noted is the excellent article of Dr. Alice Hamilton.[1] Most of this literature is of English origin. Some contributions have appeared from German sources, particularly in reference to tetrachlorethane or dope poisoning, and in reference to benzene poisoning; but most of it is not available to use at this time. As no case of optic atrophy or of definite multiple peripheral neuritis has been reported, so far as the literature to which we have access shows, the following case may be of interest.

REPORT OF CASE

History.—J. B., man, aged 39, married, foreman in munitions factory, seen April 15, 1917, had one brother, five sisters and three children living and well. None were dead. The patient's father died at 63 of an accident. The mother died at 82 of old age. His general health had been good and he could recall no serious illness or injury. He had used very little tobacco and practically no liquor. There was no evidence of venereal disease, either by direct or indirect questioning. He had married at 35. He had worked in a munitions factory for two years, and before that as a fireman. In the factory his work had been with trivalene, a plant name for binitrotoluene.

Present Illness.—About one year before, one year after entering the plant, he first noticed numbness and prickling in the feet; in the course of five months this gradually spread to the knees. He had no pain, but described the sensation as "like an electric tickling." At the end of the five months he was placed on outside work, and in the course of one month the numbness gradually grew less, but did not wholly disappear from the feet. After one month of other labor, he returned to his work in the trivalene plant as foreman, and in this position did not come quite so closely into contact with the trivalene as before. For five months there was no special change in his condition, but he still had the numbness in the feet. At the end of five months he returned to his former work of direct handling of the trivalene in the "sweat house." In one week the numbness had increased in the feet and legs. Directly after, early in December, his sight began to fail, objects appeared blurred, and he could not see well to read. His vision was then 20/40 in the right eye and 20/70 in the left eye. He was slightly cyanotic and appeared anemic. Shortly after, he noticed a little numbness in the tips of the fingers, and this had continued ever since but had not changed much. During the month of March his eyesight failed rapidly, and he quit work, April 5, 1917. At this time, vision was 20/200 in each eye. Since then his sight has failed further; April 8, vision was 5/200 in each eye. At present he can get about without difficulty, but he cannot make out even the largest print and cannot even make out the outline of a face. The left eye is a little worse than the right. There is no history of jaundice or gastritis and no loss of sexual, bladder or rectal control.

When asked to give the experiences of other men who worked with him, the patient stated that when foreman he had a crew of four men working under him; but as they habitually did not like the work or could not stand the fumes of the trivalene, they were constantly changing, and he is unable to describe the effect of the trivalene very accurately on them. One man worked for about six months handling the trivalene, and in that time developed a numbness and swelling of the feet so that he could not put on his shoes. He quit in the spring, worked on a farm all summer, and recovered, but did not return to the plant. One man has worked in the trivalene for eight months with no apparent ill effect. He takes no special precautions. Two or three other men who worked varying periods of time complained of numbness and tingling in their hands and feet and of difficulty in their gait, and headaches were frequent among the workers. All the men are provided with good leather gloves; but the trivalene, which is oily as they begin handling it and later turns to a crystalline substance, soon saturates their gloves so that they have little protection even over the hands.

Physical Examination.—The patient is a well developed and well nourished man, slightly pale; height 5 feet 6 inches, usual weight 156 pounds, and present weight 148 pounds. In a period of four days of observation his temperature ranged from 97 to 98.2, pulse 55 to 71, but usually about 60, and blood pressure 134 systolic and 81 diastolic. The tonsils were submerged and showed no special signs of inflammation; the teeth were badly worn, and there was a moderate degree of pyorrhea and gingivitis. The glands were not enlarged; the lungs were normal. Except for a moderate thickening of the blood vessels, the circulatory system was negative. Liver and splenic dulness were not altered, and the spleen was not palpable. There was no abdominal tenderness.

All the cranial nerves were normal except as noted below. With the right eye the patient counted fingers at 14 inches and with the left at 10 inches. The visual field was normal to rough tests except that there was some unusual dulling at the central point. The fundus showed a rather well developed atrophy with pale disk and some swelling of the veins and contraction of the arteries. The right pupil was somewhat larger than the left. The left reacted fairly and the right poorly to light, and both only fairly to distance.

1. Hamilton, Alice: Industrial Poisons Encountered in the Manufacture of Explosives, THE JOURNAL A. M. A., May 19, 1917, p. 1443.

Both had had "drops" instilled some days previously. A watch was heard in the right ear at 18 inches and in the left at twelve inches. Air conduction was better than bone in both, and the Weber test was negative. There were no subjective sounds at the time of the examination, but the patient stated that at the time he quit work he had "rumbling sounds" in both ears. Vibration sense was lost in the toes but present in the malleoli and upward. Joint sensibility was distinctly impaired in the toes. Neither sense showed any impairment in the fingers. Pain (pin prick) was usually appreciated in the fingers and in the feet and toes, but touch (cotton) was impaired in both. Tendon and muscle pain sense were normal. There was no incontinence of urine or feces, and sexual power was not impaired. Sweating was evident in the hands and feet.

The muscles were of good volume and tone, but the patient insisted that his strength was much impaired and that his legs would often give way under him. In all the tests he gave very fair responses. He complained of stiffness and of an occasional pulling up or jerking of the feet and legs, especially at night, and said that this seemed like an "electric shock." Coordination was good in the upper extremities and impaired in the lower. The patellar and abdominal reflexes were present but diminished. The Achilles, biceps, triceps, supinator, jaw, pharyngeal, palate, plantar, anal, bulbocavernosus and cremasteric reflexes were normal. There was no patellar or ankle clonus. A blood test revealed: hemoglobin, 80 per cent.; red cells, 4,900,000; white cells, 8,000: differential count: polymorphonuclears, 73.5 per cent.; small mononuclears, 19.5 per cent.; large mononuclears, 5.5 per cent.; eosinophils, 0.5 per cent.; other forms, 1 per cent. The cerebrospinal fluid was clear with no undue pressure. The Wassermann, Nonne, and gold tests and cell count were negative. The Wassermann test was also negative in the blood.

Treatment and Results.—Under treatment with laxatives and potassium iodid and sweating, the patient improved after about two months and has shown steady improvement since. In the month of February, 1918, he still complained of tingling and numbness in the toes. His vision was then 20/30 in the right eye and 20/30 in the left eye.

COMMENT

Binitrotoluene, known under the name of trivalene in the plant where this man worked, is the product of the second step in the nitration of toluene. When received as monotrinitrotoluene it is a heavy dark cherry colored oil, and in the process of the second nitration it changes to a crystalline substance looking much like brown sugar. As such it has a faint odor of bitter almonds and a bitter, acrid taste.

Like monotrinitrotoluene it is absorbed through the skin and mucous membranes and when so absorbed seems to have a marked transient and perhaps more or less permanent effect on the central nervous system.

In this plant, in addition to the patient here reported and those mentioned by him, there were two cases of pronounced mental aberration and one of somnolence. In the mental cases no delusions or hallucinations were manifested, but rather signs of mental dulness. The men were very quiet, with an aimless tendency to seclusion. One locked himself in an outhouse and was found only after one hour's search. He seemed stupid, could not understand or answer questions, and was mildly apprehensive. He would try to hide away, even in a room that offered no concealment, but still was docile and unafraid on contact with men. This condition persisted for about forty-eight hours, with later rapid improvement and complete recovery.

The other patient had, in addition, a marked cyanosis, with weak heart action, staggering gait and fainting. Recovery occurred within a few days.

The case of somnolence was most peculiar. The patient presented the picture of alcoholic intoxication in gait, speech and general appearance, with a very strong tendency to sleep. Not only was his muscular power diminished, but his coordination was poor. He could be got to his feet, but could not stand. With support he could with difficulty use his legs and feet, but not accurately. When lying down he would fall asleep while talking, even in the middle of a sentence. He said his mind was perfectly clear, but he could not keep awake. The knee jerks were slow in response, but increased in extent. The quadriceps could be seen to contract slowly as if in voluntary movement. He complained of marked diplopia, and occasional strabismus could be observed. The pupils were normal. The condition came on abruptly, was not more than twelve hours in development, and cleared away gradually after five or six days with final complete recovery.

Livingston-Learmonth and Cunningham,[2] in an article on the effects of trinitrotoluene on women workers, divide the symptoms into two classes, irritative and toxic, and the latter again into digestive, circulatory, cerebral and special. Under cerebral symptoms they say:

> Drowsiness is very common and many workers describe it as a sort of drugged feeling. Depression, lassitude and apathy are common. Transient loss of memory, slight disorders of sight (blurred vision, etc.), and a certain amount of transient peripheral neuritis have been noted in several of our cases. In severe cases delirium, coma and convulsions occur toward the end.

As terminal symptoms of trinitrotoluene poisoning, Rice[3] mentions delirium, light-headedness and flighty utterances, followed by a stage of coma lasting about twelve hours and ending in death.

Dr. Alice Hamilton[4] says:

> The symptoms that follow inhalation of benzol and toluol fumes or absorption of these are, in mild cases as in severe ones, the symptoms of intoxication by a substance with a special action on the central nervous system: Dizziness, confusion, transient excitement followed quickly by stupor, twitching, then exhaustion, loss of consciousness, with respiration at first rapid then slow, pulse rapid, temperature low.

She further adds:[5]

> Delirium, sometimes maniacal, is not rare; tetanic convulsions with marked opisthotonus and high temperature were described in one unusual case. Three cases developed meningitis before death.

In some cases of "dope" poisoning, which is said to "act on the nervous centers," nervous symptoms have been reported. Willcox[6] quotes Dr. Heffter and Dr. Kraus, who state that in Germany, where the "dope" contains more tetrachlorethane than the English varnishes, two types of symptoms develop: (1) gastrointestinal and hepatic symptoms, and (2) nervous symptoms. The latter group of patients suffers from tremors, headaches, pains in the limbs, numbness, "pins and needles" of the extremities, loss of knee jerks and excessive sweating.

Koelsch[7] also noticed among the more marked cases of tetrachlorethane poisoning various nervous phe-

2. Livingston-Learmonth, Agnes, and Cunningham, Barbara M.: The Effects of Trinitrotoluene on Women Workers, Lancet, London, 1916, **2**, 261.
3. Rice, A.: Munition Plant Poisoning, Am. Jour. Pub. Health, 1917, **7**, 273.
4. Hamilton, Alice: U. S. Dept. Labor, Bureau of Labor Statistics, Whole No. 219, May, 1917.
5. Hamilton, Alice: Month. Rev. Labor Statistics, 1917, **5**, No. 2.
6. Willcox: Lancet, London, 1915, **1**, 544.
7. Koelsch: München. med. Wchnschr., Nov. 16, 1915.

nomena, as headache, paresthesias in the extremities, tremor of the hands, and paralysis.

Benzene (benzol, C_6H_6) and its homologues, according to Lehmann,[8] produce in man a condition resembling intoxication, dizziness, headache and gastrointestinal disturbances; after a prolonged inhalation, motor and sensory symptoms develop.

These appear to be the only descriptions in literature available to us referring to any special effect on the nervous system; but the references here to blurred vision, transient peripheral neuritis, pains in the limbs, numbness, pins and needles, loss of knee jerks, etc., suggest clearly an involvement of the peripheral nerves and possibly also of the optic nerves.

As far as possible we have excluded other sources of poisoning in our case, and the evidence appears to us sufficiently strong to classify it under the heading given. The failure to show a loss or even marked diminution of the deep reflexes of the lower extremities we believe to be due to a possible beginning involvement of the lateral columns of the cord, suggested by the jerking of the legs and the sense of stiffness.

POSTMORTEM FINDINGS IN MEASLES-BRONCHOPNEUMONIA AND OTHER ACUTE INFECTIONS *

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During the past winter, necropsies were performed in sixty-two cases at Camp Zachary Taylor, Ky. The patients were soldiers, with one exception white, native born, physically and mentally sound, in the third decade of life, most of them country bred and from the central states. This uniformity of type permits comparative study.

The pathologic observations hereinafter described will confirm and amplify the observations reported by H. L. Alexander[1] that the infections at this camp underwent a changing history from pneumococcal, to measles, to streptococcal. It is shown that with the changes of the etiologic agent there was a distinct change in the pathologic condition of the lungs, parenchymatous organs and serous surfaces. The clinical side has been presented by Fox and Hamburger.[2]

In the fall of 1917, the etiologic agent was the pneumococcus with its customary results. Measles appeared late in October, causing the first death, November 7, from what is considered a typical measles pneumonia, with a catarrhal or purulent bronchitis. On the advent of the streptococcus infection, causing the first death, December 13, the pathologic picture changed, the bronchitis being now hemorrhagic, the pneumonia patchy and hemorrhagic, while the causative organism began to show a predilection for serous surfaces.

The principal causes of death as determined by necropsy are given in Table 1. Complicating lesions, occurring practically always, are not listed in this table as they are fully discussed later.

It is seen from this table that fifty-two of the sixty-two deaths were produced by acute infectious diseases, and that lesions of the lungs and meninges contributed, with one exception, all the primary lethal causes. It is a noteworthy fact that the intestinal tract was not involved in any of the infections, and no transmissible disease of it was responsible for death. This means that in this camp no typhoid, paratyphoid, dysentery, winter cholera or food poisoning and the like occurred. The ten deaths due to noninfectious diseases were mainly surgical affections or accidents not incurred in line of duty. These are not considered in this paper.

BRONCHOPNEUMONIA

Bronchopneumonia was the lesion most frequently found, thirty-five of the fifty-two cases presenting this change; in twenty-seven it was looked on as a primary cause of death.

To study more closely the effect of the various etiologic agents on the disease picture, all cases of bronchopneumonia are grouped into four classes:

A. Following measles; the *Streptococcus hemolyticus* isolated; 3 cases.

B. Following measles; the *Streptococcus hemolyticus* not isolated; 13 cases.

C. Not following measles; the *Streptococcus hemolyticus* isolated; 10 cases.

D. Not following measles; the *Streptococcus hemolyticus* not isolated; 9 cases.

The bronchopneumonia, then, was preceded by measles in sixteen instances, and not preceded by measles in nineteen cases. The streptococcus was isolated in thirteen cases, and not isolated in twenty-two cases. In the latter group the pneumococcus was frequently found. In a small number of cases, no bacteriologic studies were made.

TABLE 1.—CAUSES OF DEATH AS DETERMINED BY NECROPSY

Bronchopneumonia	27	Meningitis, meningococcic	5
Lobar pneumonia	8	Meningitis, streptococcic	3
Empyema, primary	6	Meningitis, pneumococcic	1
Pericarditis, primary	1	Meningitis, following mumps	1
Noninfectious diseases	10		

The points analyzed are: the time of occurrence of bronchopneumonia after the first definite symptoms of measles appeared; the duration of the bronchopneumonia from the day it was first recognized to the day of death; the type of bronchopneumonia, and the changes in the viscera. Of the latter only the pleurae, bronchi, spleen and kidneys showed constant and important alterations. The results are collected in Table 2.

TYPES OF BRONCHOPNEUMONIA

Four anatomic types of bronchopneumonia were observed. These were found with such regularity that they were classified as Types I a, I b, II and III. The first two types were mainly found in bronchopneumonia following measles; the last two in hemolytic streptococcic infection.

Type I a. The lungs are large, expanded, and very heavy. The weight of each lung ranges from 600 to 1,100 gm., the combined weight often approaching 1,500 gm. The pleural surface may be smooth and glistening, but more often is dulled and overlaid with fibrin exudate. The general surface of the lung is mottled, dusky gray-red with a distinct bluish tint. Small, ill defined areas of elevation and depression are often seen. On palpation, innumerable small, firm areas are

8. Lehmann: Arch. f. Hyg., 1911.

* From the Cantonment Laboratory, Base Hospital, Camp Zachary Taylor, Ky.

1. Alexander, H. L.: Hemolytic Streptococcus Causing Severe Infections at Camp Zachary Taylor, Ky., THE JOURNAL A. M. A., March 6, 1918, p. 775.

2. Fox, Herbert, and Hamburger, W. W.: The Streptococcus Epidemic at Camp Zachary Taylor, Ky., THE JOURNAL A. M. A., June 8, 1918, p. 1758.

felt throughout all the lobes. The lungs may be said to have a "shotlike" feel. The intervening lung tissue is boggy. The cut surface is pale bloody-red; light pressure causes the outpouring of a large amount of moderately bloodstained, frothy serum. Scattered over the entire cut surface are numberless rounded, light gray-red, definitely raised firm areas, appearing very much like large, gray miliary tubercles. They usually distinctly surround a small bronchial branch, and measure from 3 to 5 mm. in diameter. About one half to one third of the entire lung tissue is taken up by these consolidations.

The bronchial branches stand out distinctly; from many, a thick, yellow, purulent fluid exudes. The bronchial mucosa is swollen and somewhat reddened. In some instances the bronchial tubules are dilated, forming small and rather smooth-walled cylindric or globular bronchiectases. The peribronchial lymph nodes are swollen, juicy, and dark grayish red. Their cut surface is very moist and has a mottled appearance.

Type I b. This is a later stage of the preceding process. All the various anatomic changes are more accentuated. The pleura is generally covered with soft yellow exudate. The organ is markedly distended and the combined weight of the lungs approximates 2 kg. The surface of the lung lacks definite rounded contour, showing many smaller and larger elevations, blue, reddish brown or purplish in appearance fading gradually. Subpleural punctate hemorrhages are occasionally encountered. The nodules palpated are larger than in the preceding type, but are of approximately uniform size. No large consolidated patches are felt. The anterior edges of the lung and the upper lobes may be inflated. The cut surface is moderately bloody. The general color is grayish red; innumerable well outlined, slightly, but definitely raised areas of a yellowish, grayish red or dark reddish brown surround the bronchial tubes. These consolidations vary from about 5 mm. to 1 cm. in diameter. The grayish areas are quite firm, while the yellowish patches are more or less softened. The bronchi show the same general changes as in the preceding type.

The principal features of Types I a and I b are, then, marked edema, the discrete character of the consolidations, *their distinct peribronchial situation* and their occurrence in all lobes. They vary in color, size and consistency, being small, firm and light gray in the earliest stages and then becoming larger, grayish red, dark red, and finally yellow and softer in appearance and consistency. The aggregate total of these areas would equal from one third to two thirds of the entire pulmonary substance, depending on the stage. A purulent bronchitis accompanies the lesions. The marked edema and the very small size of the consolidations often obscure the clinical picture of bronchopneumonia.

Type II. The pleura usually shows inflammation; empyema is often present and the lung is slightly or not at all enlarged. On palpation, various sized areas of resistance are noted. On section, the lung tissue is not nearly so moist as in types I a and I b. The areas of consolidation are several centimeters in diameter, of irregular contour, slightly or indefinitely raised *and not visibly peribronchial.* They vary in color from dark red to grayish yellow and often show a surrounding hemorrhagic zone. Usually the lesions are confined to one or two lobes. The bronchial branches are not unduly distinct and almost always show a deep red hemorrhagic mucosa and exude a sanguineous or sanguinopurulent fluid. The peribronchial lymph nodes are large and more reddish than in Types I a and I b. This type of bronchopneumonia resembles the ordinary kind seen in the necropsy room excepting the great frequency with which empyema occurs and the hemorrhagic character of the bronchitis.

Type III. Confluent bronchopneumonia or pseudolobar lobular pneumonia. A large part of a lobe is consolidated. The cut surface is moist and finely granular; the granularity being less distinct than that of lobar pneumonia. The lobes show several distinctly different processes. While the general color is brownish red, there are areas more yellowish and others more grayish or reddish; but all fade into one another, so that the end-picture appears at first glance more homogeneous than heterogeneous. The pseudolobar pneumonia is, therefore, made up of a number of units placed so closely together that they give the appearance of a single large consolidated patch.

MEASLES-BRONCHOPNEUMONIA

Table 2 shows that nine of the sixteen cases of bronchopneumonia following measles were of Types I a or I b. The spleen was slightly enlarged, being about one and one half to twice its normal size and averging 225 gm. in weight. The capsule was smooth and transparent, the outside cover being bluish red. The organ was somewhat less firm than normal, the cut surface dull red, the trabeculae of usual size; the splenic follicles were prominent, a light yellowish gray, and about twice their normal size. The splenic pulp showed no gross changes. The splenic picture is, therefore, one usually termed "acute follicular splenitis."

In five cases not showing Type I bronchopneumonia, complications were present which may have influenced the character of the lung lesions. In two instances a streptococcic infection was superimposed. In others, epidemic meningitis, lobar pneumonia and erysipelas coexisted. As to the development of the bronchopneumonia after the onset of measles and as to its duration, no uniformity existed, as can be seen in Table 2. The kidneys, in a majority of cases, showed various grades of acute parenchymatous nephritis.

ETIOLOGY OF MEASLES-BRONCHOPNEUMONIA

One of the dominant symptoms of measles is bronchitis appearing early and often persisting. The cause of this bronchitis is not known, but it is reasonable to suppose that it is due to the virus of measles. In this connection, I would call attention to the recent work of Tunnicliff,[3] who isolated a small anaerobic coccus from the blood in forty-two out of fifty cases of measles. In the present epidemic, hemolytic streptococci appeared in the throat in a large percentage of the cases of measles, general medical cases as well as apparently normal cases. Detailed bacteriologic figures will be given in a further paper by Levy and Alexander.[4] The great invasive power and virulence of the streptococcus found in the present epidemic is demonstrated at necropsy by the extensive involvement of all the principal organs. It is most likely that they will readily thrive in an already pathologic field, that is, the inflamed bronchial tubes of measles. In the early postmortems, before the epidemic of streptococcus had appeared, a definite type of measles-bronchopneumonia was found, here termed Type I a and Type I b. The anatomic picture was essentially the same as that seen for several years in the necropsy room of the Philadelphia General Hospital by myself, and which has been described by several observers. From a study of the necropsies here, I am inclined to believe that a true measles-bronchopneumonia, caused by the virus of measles, exists. Since, however, a number of organisms, as pneumococci and streptococci, occur almost constantly in the throat, secondary invasion will take place in the bronchial system and

3. Tunnicliff, Ruth: The Cultivation of a Micrococcus from Blood in Pre-Eruptive and Eruptive Stages of Measles, THE JOURNAL A. M. A., April 7, 1917, p. 1029.

4. Levy, R. L., and Alexander, H. L.: The Predisposition of Streptococcus Carriers to the Complications of Measles, THE JOURNAL A. M. A., to be published.

one or another organism will be found in the bronchial branches and pulmonary lesions. If these organisms possess marked virulence and invasive powers, and if they intrude early in the disease, the anatomic picture will be determined by the invading bacteria, and the possible influence of the measles virus may be

TABLE 2.—FINDINGS IN THIRTY-FIVE CASES OF BRONCHOPNEUMONIA

No.	Days after Onset of Measles	Duration, Days	Type	Pleurae	Bronchi	Spleen	Kidney	Other Findings
A. Following measles; due to Streptococcus hemolyticus (3 cases)								
18	..	4	I b	R., empyema	Acute purulent bronchitis	Acute diffuse splenitis	Acute parenchymatous nephritis	Acute fibrinous peritonitis; acute fibrinous pericarditis
34	6	25	II	Double empyema	Acute hemorrhagic bronchitis	Acute follicular splenitis	Acute parenchymatous nephritis	
41	14	9	II	Normal	Acute hemorrhagic bronchitis	Acute hemorrhagic splenitis	Cloudy swelling	Thrombosis of left first sinus; left otitis media
B. Following measles; Streptococcus hemolyticus not isolated (13 cases)								
5	4	7	I a	Normal	Acute purulent bronchitis	Acute follicular splenitis	Acute parenchymatous nephritis	
6	6	9	I b	Acute fibrinous pleurisy	Acute purulent bronchitis	Acute diffuse splenitis	Cloudy swelling	
7	..	..	I b	Acute fibrinous pleurisy	Acute purulent bronchitis	Acute follicular splenitis	Acute parenchymatous nephritis	
11	..	4	I a	Normal	Acute purulent bronchitis	Acute follicular splenitis	Acute parenchymatous nephritis	
12	..	8	I b	R., serofibrinous pleurisy; L., acute fibrinous pleurisy	Acute purulent bronchitis	Acute follicular splenitis	Acute parenchymatous nephritis	Erysipelas
13	..	25	II	Normal	Acute catarrhal bronchitis	Acute follicular splenitis	Cloudy swelling	Acute epidemic meningitis
19	7	8	I b	L., acute fibrinous pleurisy	Acute hemorrhagic bronchitis	Acute diffuse splenitis	Acute parenchymatous nephritis	
21	11	4	III	R., acute fibrinous pleurisy	Acute purulent bronchitis	Acute diffuse splenitis	Acute parenchymatous nephritis	
25	11	8	I a	R., acute fibrinous pleurisy	Acute purulent bronchitis	Acute diffuse splenitis	Normal	
26	17	7	II	Double empyema	Acute hemorrhagic bronchitis	Acute diffuse splenitis with hemorrhage	Acute parenchymatous nephritis	
29	6	15	II	Normal	Acute catarrhal bronchitis	Acute diffuse splenitis	Cloudy swelling	Erysipelas, double otitis media
32	16	6	II	R., empyema	Acute hemorrhagic bronchitis	Acute follicular splenitis	Acute parenchymatous nephritis	Lobar pneumonia
40	7	4	I a	L., acute fibrinous pleurisy	Acute purulent bronchitis	Acute follicular splenitis	Acute parenchymatous nephritis	
C. Following measles; due to Streptococcus hemolyticus (10 cases)								
35	..	..	II	R., empyema	Acute hemorrhagic bronchitis	Acute follicular splenitis	Acute parenchymatous nephritis	Acute serofibrinous pericarditis
43	..	8	II	Normal	Acute hemorrhagic bronchitis	Acute diffuse splenitis		Acute purulent meningitis, thrombosis left lateral sinus, double otitis media
45	..	9	II	L., acute serofibrinous pleurisy	Acute hemorrhagic bronchitis	Acute diffuse splenitis with hemorrhage	Cloudy swelling	Acute fibrinous pericarditis
44	..	6	II	R., empyema	Acute hemorrhagic bronchitis	Acute diffuse splenitis with hemorrhage	Acute parenchymatous nephritis	Acute fibrinous pericarditis
31	..	10	II	L., empyema	Acute hemorrhagic and purulent bronchitis	Acute follicular splenitis with hemorrhage	Acute parenchymatous nephritis	
32	..	..	II	L., acute fibrinous pleuritis	Acute hemorrhagic and purulent bronchitis	Acute hemorrhagic splenitis	Acute parenchymatous nephritis	Acute otitis media; acute left mastoiditis; acute suppurative myositis and arthritis
33	..	11	II	Normal	Acute hemorrhagic and purulent bronchitis	Acute diffuse splenitis	Cloudy swelling	Acute hemorrhagic encephalitis
37	..	4	II	R., empyema	Acute hemorrhagic and purulent bronchitis	Acute follicular splenitis with hemorrhage	Cloudy swelling	Acute pleural pericarditis
38	..	22	III	R., empyema	Acute purulent bronchitis	Acute follicular splenitis	Acute parenchymatous nephritis	Acute right mastoiditis
42	..	6	I a	Double empyema	Acute hemorrhagic and purulent bronchitis	Acute diffuse splenitis	Acute parenchymatous nephritis	
D. Not following measles; streptococcus not isolated (9 cases)								
2	..	10	II	Acute fibrinous pleurisy	Acute purulent bronchitis	Acute diffuse splenitis	Acute parenchymatous nephritis	
4	..	4	II	Normal	Acute catarrhal bronchitis	Acute diffuse splenitis	Acute parenchymatous nephritis	Acute purulent meningitis
10	..	16	II	Normal	Acute purulent bronchitis	Acute follicular splenitis	Cloudy swelling	Lobar pneumonia
15	..	4	II	Normal	Acute catarrhal bronchitis	Acute follicular splenitis	Cloudy swelling	Acute meningococcic meningitis
22	..	8	II	R., empyema	Acute purulent bronchitis	Acute follicular splenitis	Acute parenchymatous nephritis	
23	..	6	II	R., empyema	Acute purulent bronchitis	Acute follicular splenitis	Cloudy swelling	Acute pericarditis
29	..	..	II	Double acute fibrinous pleuritis	Acute purulent bronchitis	Acute follicular splenitis	Acute parenchymatous nephritis	Pyemia from self-inflicted wound
45	..	12	II	Normal	Acute catarrhal bronchitis	Acute follicular splenitis	Cloudy swelling	Acute meningococcic meningitis
60	..	8	II	Normal	Acute catarrhal bronchitis	Acute diffuse splenitis	Acute parenchymatous nephritis	Acute meningitis; cause undetermined

obscured. In fact, the lesions established will be a true streptococcic or pneumococcic bronchopneumonia. If, on the other hand, the invading organisms enter the system late in the disease, are few in number, or do not possess marked virulence and invasive powers, they will influence the pathologic process slightly or not at all, and a true measles-bronchopneumonia will be produced. This explanation would readily fit our anatomic findings. I greatly regret that because of certain technical accidents, our microscopic sections have been largely unfit for study; for this reason, only the gross anatomic picture is given.

STREPTOCOCCIC BRONCHOPNEUMONIA

The majority of cases of streptococcic bronchopneumonia were of Type II. The bronchi showed hemorrhagic inflammation. Empyema occurred frequently. The spleen presented the picture of an acute splenitis often with hemorrhages, or a distinct hemorrhagic condition; it was slightly enlarged, having a smooth capsule of a slaty color or dark red. The consistency was flaccid, the cut surface pale grayish brown and often containing irregular dark red hemorrhagic areas; the follicles and trabeculae were indistinct.

Otitis media, mastoiditis, and other complications were frequently present. The mastoiditis was characterized by reddish black discolorization of the bone, which was so necrotic that it could be easily cut with a knife. Subserous hemorrhages, usually small and of pin-point size, were frequently encountered on the pleural, pericardial, renal, cerebral and hepatic surfaces. Similar hemorrhages were found in the mucosa of the renal pelvis, the stomach and the intestine. In a general way, organic changes were more widespread and of greater severity in the streptococcic infections.

BRONCHOPNEUMONIA NOT FOLLOWING MEASLES AND NOT STREPTOCOCCIC

Cases of bronchopneumonia not following measles and not streptococcic occurred usually as a complication of some other disease (Table 2). The lung picture was classified as Type II, but, as the table shows, the bronchial and visceral changes were less pronounced.

LOBAR PNEUMONIA AND COEXISTENT LOBAR AND BRONCHOPNEUMONIA

The eight cases of lobar pneumonia resemble, in every way, those usually encountered. In three, coexisting bronchopneumonia was found, in all of which the pneumococcus was isolated. One pneumonic lung presented an interesting picture. The entire right lung was consolidated; the upper and middle lobe had a grayish red cut surface, granular in appearance, from which pneumococcus cultures were made. The lower lobe possessed a distinctly more reddish appearance, and from this part hemolytic streptococci were isolated. It may be that the streptococcic and pneumococcic inflammation coexisted, or, what is more likely, the streptococcus process was superadded to the pneumococcic involvement.

EMPYEMA

The necropsies during the past winter showed an unusually high percentage of empyema, this condition being present in 21 of 52 cases. (The term "empyema" is here used to include serofibrinous pleurisy. In the table these two stages of the same process are separated.)

Clinically, a "cold" or "sore throat" frequently preceded the empyema by a few days; then, after exertion, or without discoverable cause, the following syndrome was noted: a chill, which is described as severe and sometimes lasting for an hour followed by a cough, pain in the side, fever and dyspnea. This clinical history, with the finding of dulness in the side often lead to the diagnosis of lobar pneumonia. The roentgen ray and clinical studies showed that the empyema was of unusually rapid occurrence, often developing over night.

Table 3 shows the locations of the empyema, the condition of the lung, the organism isolated, and coexisting inflammation of the peritoneum and pericardium. It is seen that only five cases of measles were complicated by empyema; in ten instances "sore throat" or a "cold" preceded the disease. The organisms found were: hemolytic streptococcus, fourteen; pneumococcus, five; no growth, and undetermined one each. In all cases the fluid obtained at necropsy was distinctly turbid, in most cases frankly purulent. It usually was a thick, yellow and creamy liquid, in which large clumps of fibrin floated. Occasionally a greenish tint was found, and, in the streptococcic cases, a brownish, light coffee color. The quantity varied from 100 to 2,500 c.c.; this variation is in part due to previous aspiration or operation. In nine instances the right, in eight the left, in four both pleural cavities were affected. In the latter, various developmental stages could be observed; the empyema was walled off or pocketed by a tough, fibrinous adhesion between the lung and the lateral chest wall. Interlobar empyema was only once found. Sometimes only one, sometimes several pus pockets were present; a certain amount of free basal empyema usually existed. These cases were of considerable clinical interest since drainage proved difficult and occasionally a large pocket was not reached, while another was perfectly emptied. In all cases of empyema, the pleural surface was almost completely enveloped by a thick coat of yellow, soft exudate averaging from 3 to 10 mm. in thickness, and binding the lung lightly to the chest wall here and there. If the exudative process had existed for some time, organization occurred. The pleural surface then was grayish, and had a somewhat scaly, dry appearance. The exudate was much tougher and adhesion firmer; in the latter cases empyema pockets were found. This would seem to indicate that, other conditions permitting, early operations offer the best chance for complete drainage. The changes in the lung were usually those of bronchopneumonia; lobar pneumonia was found only in one case. The lung on the infected side showed compression varying in degree with the quantity of fluid present. In several instances the lung was no larger than a fist, having then a dry fleshy appearance and a tough meat feel. The cut surface was dark red, airless and dry, the bronchial branches standing out prominently because of the loss of separating tissues. More often than atelectasis of the entire lung, compression of only one lobe was found; this had the same appearance as described above. The uninvolved side showed compensatory inflation, the organ being widely distended and hypercrepitant.

In six cases no inflammatory changes were present in the lungs, and the empyema had to be looked on as primary. The lung tissue was carefully examined in these cases; and while it is conceivable that the existing atelectasis obscures the inflammatory changes,

careful study failed to reveal any. Five of these primary empyemas were streptococcic in origin. In the other, no organism was isolated.

ACUTE PERICARDITIS

Ten instances of acute pericarditis were discovered, with one exception, in the serofibrinous or purulent stage. One case was preceded by measles, another by "rheumatism." The hemolytic streptococcus was isolated six, the pneumococcus four times (twice Type II, once Type I, once, type not determined). Lobar pneumonia existed in one of the cases, bronchopneumonia in six, and in three instances the lung did not show any inflammatory processes. In all but one patient the pericardial inflammation was associated was almost always normal. The atheromatous lesions numbered from a very few to several dozen. They were subintimally located, and varied in consistency from hyaline firmness to definite softening. The coronaries showed distinct involvement in a considerable number of cases. Since the common causes of aortic disease, syphilis and other chronic infections, are not to be elicited in the history or necropsy findings, one is forced to consider the possibility that the present infection is the cause of the intimal changes, which speculation points out that close observation should be made of aortas in these young men coming to necropsy from acute infections. Since our patients are only in the third decade of life, the presence of aortic change is of interest.

TABLE 2.—FINDINGS IN EMPYEMA AND SEROFIBRINOUS PLEURITIS

No.	Preceding Disease	Pleura	Lung	Organism Isolated	Remarks
12	Measles	R., serofibrinous pleurisy L., fibrinous pleurisy	R., bronchopneumonia L., bronchopneumonia	Pneumococcus	
16	"Cold"	R., empyema L., normal	R., compress-atelectasis L., compensatory inflation	Streptococcus hemolyticus	No inflammatory changes in lungs; moderate purulent bronchitis
18	Measles	R., normal L., empyema	R., bronchopneumonia same compress.-atelectasis	Streptococcus hemolyticus	Acute pericarditis; acute peritonitis
22	"Cold"	R., empyema L., normal	L., bronchopneumonia R., compress-atelectasis L., bronchopneumonia	Pneumococcus	L., few bronchopneumonic areas; R., show none, but marked purulent bronchitis
23	.....	R., normal L., empyema	R., bronchopneumonia L., compress-atelectasis	Pneumococcus	Acute pericarditis
26	Measles	R., serofibrinous pleurisy L., empyema	R., bronchopneumonia L., compress-atelectasis		
27	.....	R., normal L., empyema	R., normal L., infarct, upper lobe; compress-atelectasis	Streptococcus hemolyticus	No inflammatory changes in lungs; hemorrhagic bronchitis and tracheitis
29	.....	R., normal L., serofibrinous pleurisy	R., compensatory inflation L., compress-atelectasis	.....	No inflammatory changes in lungs; hemorrhagic bronchitis and tracheitis
32	Measles	R., empyema L., normal	R., bronchopneumonia L., bronchopneumonia	Pneumococcus	
34	Measles	R., empyema L., serofibrinous pleurisy	R., bronchopneumonia L., bronchopneumonia; compress-atelectasis	Streptococcus hemolyticus	
35	"Cold"	R., empyema L., empyema, early	R., bronchopneumonia; compress-atelectasis L., compensatory inflation	Streptococcus hemolyticus	Acute pericarditis
37	"Sore throat"	R., serofibrinous pleurisy L., normal	R., lobar pneumonia L., compensatory inflation	Pneumococcus	Acute peritonitis
38	"Rheumatism"	R., normal L., empyema	R., compensatory inflation L., compress-atelectasis	Streptococcus hemolyticus	Acute pericarditis; no inflammatory changes in lungs
39	"Cold"	R., normal L., empyema	R., compensatory inflation L., compress-atelectasis	Streptococcus hemolyticus	No inflammatory changes in lungs
42	.....	R., normal L., serofibrinous pleurisy	R., bronchopneumonia L., bronchopneumonia; compress-atelectasis	Streptococcus hemolyticus	Acute pericarditis
44	"Sore throat"	R., empyema L., normal	R., compress-atelectasis; bronchopneumonia L., bronchopneumonia	Streptococcus hemolyticus	Acute pericarditis
9	.....	R., normal L., empyema	R., compensatory inflation L., compress-atelectasis	Streptococcus hemolyticus	No inflammatory changes in lungs; acute pericarditis
51	"Sore throat"	R., normal L., empyema	R., bronchopneumonia L., bronchopneumonia	Streptococcus hemolyticus	
57	"Cold"	R., empyema L., normal	R., bronchopneumonia L., bronchopneumonia	Streptococcus hemolyticus	Acute pericarditis
58	"Sore throat"	R., empyema L., normal	R., compress-atelectasis L., bronchopneumonia	Streptococcus hemolyticus	
62	"Cold"	R., empyema L., empyema	R., bronchopneumonia L., bronchopneumonia	Streptococcus hemolyticus	Acute peritonitis

with empyema. In one case the pericarditis was looked on as primary, since no inflammatory processes in other organs were found present. In this case hydrothorax and ascites of undetermined origin were found. The findings are grouped together in Table 4.

CHANGES IN THE CARDIOVASCULAR AND THE ABDOMINAL VISCERA

The heart, in the majority of cases of bronchopneumonia and lobar pneumonia, showed right-sided dilatation and cloudy swelling. The aorta, in an unusual percentage of instances, presented atheroma. In forty-two cases, detailed notes concerning the state of the aorta were made. In thirty of these, aortic atheroma was present in the form of elevated, yellow patches or streaks. They were situated mostly in the ascending arch, and to a less extent in the abdominal aorta and other portions of the arch. The thoracic aorta

The liver usually showed cloudy swelling. The gastro-intestinal tract presented no noteworthy changes.

MENINGITIS

Meningococcic Meningitis.—Five patients came to necropsy. The duration of the disease was 3, 3, 4, 9 and 25 days, respectively. The last patient had a recurrence of infection, since at one time his spinal fluid was clear and sterile. The pathologic picture was similar in all cases. This pia-arachnoid had a loose, edematous structure, and was moderately injected. Fine, yellow lines of perivascular purulent infiltration were seen, especially in the temporoparietal area. A yellow, soft exudate was found chiefly on the base of the brain from the optic chiasm to the cerebellum. The upper surface of the cerebellum showed an especially heavy deposit. In one case practically the entire brain surface was covered,

in the other the exudates were largely confined to the temporoparietal lobes. The lateral ventricles contained a turbid fluid in all cases, frank pus in one, and in two instances they were distended to twice their size, forming an internal hydrocephalus. The viscera in all patients showed cloudy swelling, the spleen was slightly follicular, and the lungs in three instances showed areas of bronchopneumonia.

Pneumococcic Meningitis. — This occurred in one instance and was associated with bronchopneumonia. The anatomic picture was similar to that of meningococcic meningitis.

Streptococcic Meningitis.—In all three cases, purulent otitis and mastoiditis was the atrium of the infection.

Parts of the mastoid and petrous bone were bluish black and necrotic. The mastoid cells and internal ear contained greenish pus. The pia-arachnoidal vessels showed greater infection than in meningococcic meningitis. The exudate had a greenish tint, and was more abundant. Punctate, subpial hemorrhages were present. Thrombosis of the right lateral sinus was

TABLE 4.—FINDINGS IN TEN CASES OF ACUTE PERICARDITIS

No.	Organism Isolated	Condition of Lung	Condition of Pleura
8	Pneumococcus	Lobar pneumonia, R., L.	Acute fibrinous pleuritis, R.
18	Streptococcus hemolyticus	Double bronchopneumonia	Empyema, L.
23	Pneumococcus	Bronchopneumonia, L.	Negative (hydrothorax)
31	Pneumococcus	Negative (compensatory atelectasis)	Negative (hydrothorax)
35	Streptococcus hemolyticus	Bronchopneumonia, R., L.	Empyema, R.
38	Streptococcus hemolyticus	Negative (compensatory atelectasis)	Empyema, L.
42	Pneumococcus	Double bronchopneumonia	Empyema, L.
44	Streptococcus hemolyticus	Bronchopneumonia, L.	Empyema, R.
49	Streptococcus hemolyticus	Negative (atelectasis, L.)	Empyema, L.
57	Streptococcus hemolyticus	Double bronchopneumonia	Empyema, R.

once seen. The ventricles were overdistended in one instance, and in all cases contained semipurulent fluid. The ependyma was moderately reddened. The visceral changes were more pronounced than those of meningococcic meningitis. Parenchymatous nephritis was the principal lesion noted.

Hemorrhagic Encephalitis. — As has been stated elsewhere, punctate subserous hemorrhages were often observed in streptococcic infections. One case of bronchopneumonia was complicated with a marked hemorrhagic encephalitis. Clinically the patient developed delirium two days after the onset of the bronchopneumonia, and the neck became stiff. Lumbar puncture yielded clear spinal fluid containing a considerable number of polymorphonuclear cells.

The brain showed extensive subpial hemorrhagic extravasations, particularly over the frontal and superior parietal areas. The large veins were greatly congested. In the cut surfaces an unusual number of bleeding points were present. The cortex of the superior portion of the right frontal lobe contained an area of punctate hemorrhages about 2.5 cm. in diameter. In the cortex of the left parietal region a similar hemorrhagic area was found. The ventricles were normal in size, and contained a slightly blood-tinged fluid. The ependyma was normal in size. The internal ear and mastoid cells showed no evidences of inflammation. In microscopic sections, extensive subpial hemorrhages were seen. The vessels in the cortex were greatly distended, and in many instances, packed with polymorphonuclear leukocytes; at many points hemorrhagic extravasations were present in the cortex.

SUMMARY

1. The large majority of deaths were due to infectious diseases.

2. Pneumococcus infection led to a small number of deaths and gave the usual picture.

3. The fatal cases of measles showed the formerly recognized type of measles-bronchopneumonia until a highly virulent and invasive streptococcus changed the character of the pathologic lesions.

4. Empyema arose as secondary to a pneumonitis, and in six cases primarily.

5. The late streptococcus infections have a strong predilection for serous surfaces.

6. Epidemic meningitis was sporadic and of the ordinary form. No cases of spotted fever were seen.

ACUTE STREPTOCOCCIC SEPSIS WITH PURULENT POLYSEROSITIS, SPLENIC TUMOR AND HEMOLYTIC JAUNDICE

PRELIMINARY NOTE

Since the writing of this report, streptococcus infections seem to have taken on a new and highly virulent form. Four postmeasles cases came to necropsy in the week of April 28, 1918. All showed the following anatomic picture: icterus, acute purulent pleuritis, pericarditis, and peritonitis, acute splenic tumor, and multiple subserous hemorrhages.

The lungs contained a few patches of bronchopneumonia. Pure cultures of hemolytic streptococcus were obtained from the heart's blood and the exudate in the pleurae, pericardial and peritoneal cavities.

The findings appear to point to an increase in the invasive powers of the streptococci, probably because of passage through a large number of hosts. A further report will be made.

Effect of Diets on Reproduction.—In a preliminary report (*Science*, March 1, 1918), J. R. Slonaker and T. A. Card of the Department of Physiology of Stanford University summarize their findings on the effects of omnivorous and vegetarian diets on reproduction in the albino rat. The number of pairs constantly under observation was forty, with an equal number as controls, on the same vegetarian diet as the first class, with the addition of some form of animal food. The conclusions so far reached were: The vegetarians were smaller, had less vigor, were less active, had rougher hair and a tendency to sore eyes, while the other group were the reverse in these respects. The earliest ages at which young were born to the omnivorous group was 90 days, while for the vegetarian group it was 119 days, showing that the age of sexual maturity for the former group was 59 days and for the other group 98 days. The average duration of reproductive activity in the omnivorous group was 161 days and for the vegetarian group 111 days, showing that the restricted diet not only delayed the period of reproductive activity, but also shortened it. Vegetarian pairs when they ceased to reproduce were separated and new healthy omnivorous rats mated with them. All these new matings failed to reproduce. The conclusion is that the vegetarian diet produces sterility in both sexes. Only two or three generations of the vegetarian rats could be observed before the line became extinct, forcing the conclusion that the vegetarian diet not only reduces the vitality, the growth and the ability to reproduce, but also tends to the extermination of the race.

RECONSTRUCTION AND REHABILITATION OF DISABLED SOLDIERS

REPORT OF THE SECOND MEETING OF THE SECTION ON MISCELLANEOUS TOPICS, HELD IN THE AUDITORIUM THEATER, THURSDAY, JUNE 13*

The meeting was called to order by Lieut.-Col. Harry E. Mock.

CHAIRMAN MOCK said: Canada has sent two of her most influential men in the work of reclaiming her disabled soldiers to talk to the American Medical Association and to the people of Chicago. The first, Major John S. Todd, Canada, has seen service in France and is now giving his time and service to the disabled soldiers of Canada.

The Reconstruction of the Canadian Crippled Soldiers and Results

MAJOR JOHN C. TODD said: This meeting is a good thing because our success in this war is going to depend on that which each individual of us does, and success in the war is going to be won no less overseas than right here. In order that we may do what is right it is necessary that we should be correctly informed. It is for this reason that it is a good thing that medical men especially are informing themselves of the right thing to do for disabled sailors and soldiers. Men and women are prone to believe what doctors tell them. If the doctors of this country know the right thing and go about consistently and steadily repeating it, it will not be long before an accurate public opinion is general, constant, fixed, throughout the country. Physicians especially must make Americans understand what must be done by disabled sailors and soldiers and for disabled sailors and soldiers when their war service is at an end. We are all full of sympathy toward the disabled man that comes back, but just as affection for children may be a means of doing injury to a child, so may our sympathy toward disabled men be a means of doing an injury to them.

An English officer, discharged as disabled and wounded after four years of service, complained that he found it difficult to make up his mind concerning the next meal. A civilian is accustomed to order his meals, to do everything for himself. He goes into the army. He serves for four years. During that four years everything is done for him. His meals are ordered. The hour when he should go to his meals is decided for him. What he is to eat at his meals is decided. Suddenly he is wounded, no longer fit to be a soldier. He is turned out in the world and has to unlearn that which has been taught to him with pain and distress. You must help him to unlearn. It would be bad for that man if he were given a holiday for one year without any instruction and preparation for civilian life which is to follow. It would be bad for the country.

How are men to be educated so that they may return to civilian life? The first thing is that their disabilities must be reduced to their lowest measure by all that the wisdom of medicine and surgery can do for them. They must have their disabilities made as small as they may be by the provision of appropriate artificial appliances. The men must be made fit for employment. They must be taught employments. Most of them—80 per cent. of them—will be able to go back to full time occupations and compete with normal people, but there will be some who cannot, and even for those who can compete it will be difficult to find employment. The government must provide means for giving employment to disabled men.

A pension is not a gift. It is not something that is given to disabled men for what they have done. It is a debt paid to them in order to make up to them that measure of capacity which they have lost by reason of their service. (Applause.) You had one fault in your pension law. You should put one authority in charge of your pension legislation, make him a supreme court judge, if you will, and then let no authority interfere with his decisions. That is what has been done in Canada. I am one of three pension commissioners who have the responsibility to disabled men and to the public of Canada of justly distributing pensions, and there is no authority in Canada outside of the united will of our legislature and senate who has the power to alter our decisions.

[The Hart House Training School film was then shown, and a film illustrating "Artificial Limbs in the Making," with comment by Major Todd.]

It is very necessary that the government responsible for distributing artificial limbs to disabled men should have types of limbs made by itself. The government is responsible for keeping those limbs in repair or replacing them. If it were dependent on limbs bought in commerce there would certainly be competition among individual manufacturers, and there would not be any certainty that disabled men would get absolutely the best limb which knowledge can give to them. The Canadian government therefore has established for itself types of limbs. It distributes these to men who need them and it keeps them in repair and replaces them when they are worn out.

Because there will be large numbers of men in Canada using artificial limbs and requiring repairs to them constantly during the next generation, it has been found necessary for the government to look toward training men who will be able to repair those limbs. It will be a nuisance for a man out on a farm on the prairie to send his leg in, perhaps a couple of thousand miles, to a large city in order to have it repaired. The government is training disabled men, largely in the government limb factory, in order that they may go to their communities and set up small repair shops.

These are the general principles on which the rehabilitation of disabled men must proceed. The precise manner in which these principles will apply in the United States must depend on the nature of your own problems. There are one or two things, however, which experience in France, Great Britain, Italy and Canada can teach. One of those things is this: it is necessary to place the whole business under the jurisdiction of one central administrative power.

LIEUT.-COL. JAMES BORDLEY, JR., vice chairman, then took the chair.

The Conservation and Reclamation of the Industrial Soldiers—A War Measure

LIEUT.-COL. HARRY E. MOCK said: I am here to speak to you about another soldier, the industrial soldier, the soldier of the second line of defense, the man who belongs to that great industrial army which is just as essential to the winning of this war as is the military army, and the man who becomes disabled and wounded without the glorification that comes from such wounds by securing them on the battlefield. In England and France and that portion of Belgium that is left, and the other countries, they have done everything to increase the efficiency of the industrial army in order to speed up production for the purpose of winning the war. If this is good for war time, if these things increase production to win this war, why are they not good for peace times? They answer it themselves by saying they are. Never again will the old order of things exist after this war. Therefore it behooves this country to look forward to that period of social democracy when we are bound to have exactly the same conditions here. As the first country standing out as the land of freedom, we must be the leaders in this national, social democracy; but above that the immediate need is the need of winning the war. I am going to switch now to four lantern slides which I believe will drive home the idea I want to convey better than anything else, namely, that today the need of man power to win this war must compel us to form some means of conserving our industrial army and reclaiming the disabled from that industrial army.

This is a map showing our two armies; the first line of defense is the military army, the second line of defense is the industrial army. Two years ago at Detroit there was born a new organization, of men who were practicing industrial medicine and surgery, the keynote of which is the prevention of disease and accident among the industrial employees of this country.

This is the dream [referring to another picture on the screen] of those men, human conservation, the firm foundation of production. It is done by disease prevention, by accident prevention, plant sanitation, home sanitation, physi-

* Report of special meetings held as a part of the scientific assembly at the Sixty-Ninth Annual Session of the American Medical Association.

cal selection for jobs, adequate medical and surgical care for those disabled, good wages, good food, recreation and education. As a result, we get the maximum production, by experienced, intelligent, loyal employees.

This speaks for itself [referring to another picture]. Here are the by-products from the military army. If we have 2,000,000 soldiers in Europe, and 200,000 are disabled in a year by wounds and by disease, for that is what the figures from the other countries show, 50,000 must be physically reconstructed, and 20,000 must be vocationally retrained and otherwise reclaimed. Here is the industrial army of 30,000,000, soldiers 3,000,000, disabled every year by accidents and by disease, 800,000 that should be physically reconstructed, and 200,000 that should be vocationally retrained and otherwise reclaimed. Are we doing it? Cut out the human scrap heap, salvage the disabled, conserve human life and human energy.

The Selection of New Occupations for Disabled

(Mr. T. B. Kidner read a paper on this subject which will appear in a later issue.)

LIEUT.-COL. MOCK took the chair. He said: If the people of this country could only understand how much Mr. T. B. Kidner of Canada has given to us to help us develop our plans for the care and the reclaiming of our disabled soldiers, you would come to love him just as those of us down at Washington have who have been working with him lately. When the war came Mr. Douglas C. McMurtrie dreamed great things. He went to the Red Cross and established through their help the American Red Cross Institute for cripples in New York. After he got that going he dreamed greater dreams in establishing Red Cross institutes for cripples elsewhere. They are using the civilian cripple, studying his rehabilitation, the reclaiming of the civilian cripple, with a view of developing the best means of reclaiming the crippled soldier when we have him with us.

The Results of Rehabilitation in Foreign Countries

MR. DOUGLAS C. MCMURTRIE said: When the United States entered the war the American Red Cross looked around to see what its responsibilities would be in the field of rehabilitation, and as it thought that government plans might move a little more slowly than unofficial activities, it decided to start one experimental school of reeducation. This school was established between six and nine months ago in New York City and is known as the Red Cross Institute for Crippled and Disabled Men. Its first and most important activity is its educational department, and in this department there have already been started training classes in oxy-acetylene welding, in the making of artificial limbs, in printing, in mechanical drafting and in jewelry work. The institute also maintains an employment department which has been of considerable service during the last six months. During that time it has placed 600 seriously disabled men who could not have been placed in employment through the ordinary channels. It has also carried on a research department which it is felt has been of some use. One of our first duties was to proceed to the collection of a library and the publication of a series of studies that would bring the matter quickly and easily to the attention of the people who contemplated going into similar work. As a result of the preparation, that school could without any difficulty receive tomorrow morning 100 additional pupils and be entirely ready for them. For some time there have been carried on here some excellent training classes in preparing women to do the ward occupations and the earlier work with the men who will later be vocational cases. Through the generosity of one of the citizens of Chicago, it is also probable that there will be established here in this city before long a Red Cross institute similar to the one which I have just described to you in New York. I will interrupt my remarks here to show you a film of one of the French schools of reeducation. This film illustrates the work of the school at Montpellier, which accommodates hundreds of French war cripples. At this school they are taught various trades which have been found successful in that country.

Motor mechanics is one of the most popular trades for disabled men, and our Canadian friends tell us that practically every disabled soldier wants to take up motor mechanics. The first job of the vocational officer is to persuade him not to take that course up and to find out what he is really best fitted for. However, for the men for whom it is a wise choice it offers very good employment. In choosing trades and employments we have to look to the conditions after the war. The British minister of pensions has sent out instructions that no disabled soldiers are to be trained as automobile drivers. The reason for that is that in the present war all transportation is being done by motor trucks, and in consequence a vast army of men have been trained as chauffeurs and they have had the most remarkable experience that any one could get. After the war is over those men will come back to civilian labor and they would compete unduly with the disabled men who might be trained.

All these things may perhaps seem obvious to us, but they are certainly not obvious to the public as a whole. One of the main purposes of this meeting was to come to this audience and ask for their help in putting this principle across, in going to the public and explaining the matter and securing constructive rather than destructive cooperation. In this way we can help our disabled men to the honor of self support rather than to the ignominy of dependence. We are counting on you.

CHAIRMAN MOCK said: Since last October we have been working in Washington along two lines; one, that these men could be rehabilitated absolutely as a military proposition, and the other, that we needed the greatest possible cooperation between the military and the civilian forces to put these men back as useful units of society as civilians once more.

Mr. C. A. Prosser, of the federal Board for Vocational Education, was to be present and address you today, but at the last moment found he could not come. In his place came Mr. James P. Monroe, a business man of Boston and the vice chairman of the Board for Vocational Education.

The Federal Board for Vocational Education

MR. JAMES P. MONROE said: The federal Board for Vocational Education is made up of three members of the Cabinet, the Commissioner of Education and three lay members. We have been making a study of this subject both from the side of the industrial cripple and from the side of the war cripple ever since we were organized last July, and we have had the help not only of the Surgeon-General's Department but we have had the help of the American Red Cross through the admirable Red Cross institute in New York, to which Mr. McMurtrie has referred, and also inconceivably valuable help from the Canadian government and through such men as have appeared before you today, representing Canada. The bill which passed unanimously, when signed by the President, is the basis for action by the federal Board for Vocational Education.

The subject is, What is to become of the reconstructed soldier in civil life? We used to regard the returned crippled soldier as a pensioner. Under this new legislation and the attitude of the Surgeon-General's Office we purpose to make him a man. He used to be an object of charity. We purpose to make him an object of pride. We used to throw him on the scrap heap. We now purpose to make him one of the pillars of economic society. There is every reason and every tendency for the soldier when he finds himself more or less crippled by the war or by disease to fall into an attitude of despair and hopelessness. There will be every tendency for him to regard himself as a hero and to accept the propping up which society will be willing to give him. There will be every tendency on the part of well meaning persons to coddle him and make him soft. There is danger if he is kept too long in the process of physical rehabilitation that he will become hospitalized, and there is not a more hopeless object than a hospitalized man or woman.

Finally, there is the natural timidity of any man to take the first plunge back into industry. All those things have got to be overcome jointly by the Surgeon-General's Department and by the federal Board of Vocational Education, by the Red Cross and by all the other splendid agencies. This thing has got to be handled not on the basis of sentimentality, but on the basis of common sense. There will be the skepticism of employers, who cannot imagine a crippled man being of much use in industry. There will be the suspicion of labor, which will feel that we are going to exploit the man, on the one hand, or else that we are going to crowd our industries with cheap labor which is cheap because it is crippled. There will be, and this is one of the most serious things, there will be some day in the future hard times, when all these occupations that we may have temporarily found for the crippled man will fall like a house of cards under economic pressure, and the tendency will be to forget the debt that we owe these men and to throw them out as the first to be scrapped in industry. All those things have got to be overcome by understanding and by education of the public. The education is an entirely new field, and we have got to educate the schools and the colleges,

and especially the industries themselves all over the country, to help us in giving the right sort of vocational reeducation to these men. From the very first minute that you get hold of that man when he comes back from No Man's Land he must be encouraged to develop his initiative, and that initiative must be based first on hope, on the impression that of course he is going to have a little handicap, but on the whole he will be just as good, if not a little better fellow than he was before. It must be based on a knowledge of what is open to that man in civilian and industrial life. It must be based finally on setting before that man from the earliest possible moment, from the moment that he comes out of the ether, if possible, the idea of his working toward a definite industrial, economic and social goal.

I agree absolutely with what was said this morning, that there must be every possible opportunity for recreation and therefore there must be ample grounds; but we must not forget that while recreation is absolutely essential as a therapeutic measure, purposeful work also is an absolute essential as a therapeutic measure, and you cannot get real work that means something to the man unless you can bring him into close contact with industries. For that purpose you must have some place where there is a great variety of industries. The next essential thing, it seems to me, is that this crippled man at the very earliest date should be gotten back, as far as possible, to his old environment. In the first place, because there is no better way, in order to restore that man's normality, than to make him feel that he is just as good a man as he was before by bringing him back among his old associates and in his old vicinity. In the second place, it is necessary to enlist the social backing of the people of his home town. That is, I believe, one of the most essential things in this whole business. Therefore, I cannot see any way out of this thing except to have a great number of small restoration hospitals scattered all over the country so that the man at the earliest possible time shall be brought back into his own vicinity, and this widening out into the industries of that vicinity takes place from what you may call a local hospital.

All this work, however, will be futile unless we organize an efficient follow-up system. The men cannot be trained and turned over into an industry and then let go. We have got to have some system of follow-up to see that he really fits into that industry, to see that he does not get discouraged, to see that he is not exploited, to see that he does not, as there will be tremendous tendency among these men to do, become a rolling stone, trying first this thing and then that thing, seeking here and seeking there and each time falling down to a lower economic level. Finally, we have got to organize social agencies, such as the Red Cross, such as the local agencies, such as all sorts of things that will occur to you, to stand behind the man on the social side, to stimulate him and keep him up with that ambition which is essential, to teach him thrift, for this man is going to have a good deal of money from the government besides that which he earns, and he has got to be taught how to make that money of the most value to him. These social agencies must look after the family conditions to be sure that they are not meddling with his ambition, to be sure that they are not weighing him down with all kinds of conditions that are unnecessary, and finally to do everything they can to hold out the glad hand and to bring that man back into the normal social and economic life. That, after all, is the problem to make this man normal.

Chairman Mock said: We were to have Mr. W. Frank Pearsons, director of the Civilian Relief Division, American Red Cross. Mr. Pearsons has just returned from France and could not come on to Chicago. We have from that same division Mr. Curtis E. Lakeman.

Social and Economic Supervision of the Disabled Soldier

Mr. Curtis E. Lakeman said: The American Red Cross is carrying out, in this field of reconstruction, its characteristic function of supplementing the work of the governmental authorities. Aside from research, experimental and educational work in special institutes, there are two ways in which the Red Cross is peculiarly qualified and obligated to help.

In the first place, it can influence the family to give strong moral support to the soldier under treatment and in training, just as much as to the soldier at the front.

In the second place, it can bring to the man himself the friendly service of a big brother during the whole course of his effort to fit himself for a new occupation, and until he again stands firmly on his own feet in civil life.

The Red Cross is prepared for this duty because it is already caring for the families of soldiers and sailors, supporting their fighting morale by removing causes of worry about home conditions. This is being done so unostentatiously that little is known to the public of this Red Cross activity. There have already been organized throughout the United States more than 3,000 local committees known as home service sections. These are charged with the responsibility of maintaining American standards of family life among the dependents of enlisted men whenever the need of any form of assistance is made known.

It is a misconception to think of these committees as made up of women alone; least of all of those good-hearted but mistaken women whose oversentimental activities in the entertainment of returned soldiers constitute a menace to their true welfare. On the contrary, the type of trained women who lead in Red Cross Home Service gives a strong safeguard against this very danger. But also it is a first principle to place on each home service committee a doctor, a lawyer, a banker and a business man—leading local citizens who are qualified to give to dependents of soldiers practical advice as to their rights and duties under the War Risk Insurance Law, help them adjust mortgages, obtain good medical care, in a word, provide every form of helpfulness which will maintain the solidarity of the family. Here in Chicago over a hundred men are already enlisted as trained volunteers in the local home service section.

To these Red Cross committees in every city and county of the United States the government will be able to turn, in confidence that the follow-up of the disabled soldier is in competent and sympathetic hands. Whenever the man goes to a distant city for industrial training or to take up a new vocation, an experienced older brother will be ready and anxious to stand by him and talk over those personal problems which he may not wish to discuss with a government official, no matter how well equipped and conscientious the latter may be.

It is these committees, made up both of practical men of affairs and trained sympathetic women, that will bring a powerful influence to bear on the soldier through his family. The support of the family must be given the soldier at every stage of his hospital treatment, vocational training and early efforts to make his way in industry. The returned soldier has one more battle to fight for his country and his own future. Under the wise plan of the national government, the man must himself make the mental and physical effort to prepare for a new occupation, and a future of self support. On the education of the man's own will, not on military or economic compulsion, depends the success of the whole system. It is for the disabled soldier himself to decide whether he shall contribute to the economic and social stability of his family and his country, or shall degenerate into a mere pensioner or even a street beggar. There is not time, nor is it necessary to do more than suggest the enormous influence which the family can exert on that momentous decision. In advising the family what it can and should do to help the man, the Red Cross has the machinery already set up in its home service organization, and eagerly awaits every opportunity to discharge in this way its share of responsibility for the reconstruction of the disabled soldier.

Michael Dowling

The Michael Dowling film was shown. At the close of the showing of the film Mr. Dowling walked on the platform.

Mr. Michael Dowling said: *Ladies and Gentlemen:* I think there is danger of too much being attempted and making it too easy for the men who come back with a leg gone or an arm gone. Now, an arm being gone is a mere bagatelle, two arms don't amount to anything, and I can assure you from personal experience that it doesn't mean anything to have both legs and both hands gone. There is just as much fun in living. I used to be able to drive a team of horses just as well as anybody and used my right arm for the usual purpose in courting. I can still handle an automobile, although I think an automobile is an unnecessary nuisance to a couple who wish to get married. What the so-called cripple needs is not charity but a chance. The fight that wants to be put up at this time is not between money and opportunity or the loss of legs or the loss of arms or eyes or other members of the body, but this is a fight between General Gorgas and general despondency. Every community and every family ought to see to it that every other member of the family pays no attention to a hunchback, never looks at a man with clubfoot as he walks down the street, especially never looks at his deformity, and never looks at a man with a peg leg or with an empty coat sleeve. It should be taught in the schools. It should be preached from the pulpits.

PROCEEDINGS OF THE CHICAGO SESSION

THE SIXTY-NINTH ANNUAL SESSION OF THE AMERICAN MEDICAL ASSOCIATION, HELD AT CHICAGO, JUNE 10-14, 1918

MINUTES OF THE SECTIONS

SECTION ON PRACTICE OF MEDICINE

WEDNESDAY, JUNE 12—MORNING

The section was called to order at 9:30 by the chairman, Dr. Lawrence Litchfield, Pittsburgh.

The secretary, Dr. James S. McLester, Birmingham, Ala., read excerpts from the by-laws regarding discussion of papers.

The chairman asked Dr. W. L. Bierring, Des Moines, and Dr. Charles F. Hoover, Cleveland, to take the places on the executive committee, for this meeting, of Drs. Thomas McCrae, Philadelphia, and Roger S. Norris, Cincinnati, who were unable to be present.

The chairman named for the nominating committee Drs. Horace D. Arnold, Boston; Willard J. Stone, Toledo, and Thomas D. Coleman, Augusta, Ga.

The chairman, Dr. Lawrence Litchfield, Pittsburgh, read the chairman's address, entitled "Glucose Intravenously as a Therapeutic Agent." No discussion.

Dr. Edward C. Rosenow, Rochester, Minn., read a paper on "Further Studies in the Treatment of Acute Poliomyelitis with Immune Horse Serum." Discussed by Drs. P. S. Roy, Washington, D. C., and Edward C. Rosenow, Rochester, Minn.

Dr. Henry A. Christian, Boston, read a paper on "Pulmonary Compression Signs Associated with Fibrinous Pericarditis." Discussed by Drs. William H. Robey, Jr., Boston; H. D. Power, San Francisco; Charles G. Jennings, Detroit; George D. Head, Minneapolis; Lawrence Litchfield, Pittsburgh; Granville N. Ryan, Des Moines, Iowa, and Henry A. Christian, Boston.

Dr. Sydney R. Miller, Baltimore, read a paper on "Ulceration of the Soft Palate Resembling Syphilitic Perforating Ulcer Due to Fusiform Bacilli and Spirillae (Vincent's Angina)." Discussed by Drs. W. H. Marshall, Camp Grant, Rockford, Ill.; Frank J. Sladen, Detroit; Henry A. Christian, Boston, and Sydney R. Miller, Baltimore.

WEDNESDAY, JUNE 12—AFTERNOON

Dr. William W. Herrick, New York, read a paper on "The Early Diagnosis and Intravenous Serum Treatment of Epidemic Cerebrospinal Meningitis." Discussed by Drs. J. B. Guthrie, New Orleans; W. L. Bierring, Des Moines, Iowa; Powhatan S. Schenck, Norfolk, Va.; F. F. Russell, Washington, D. C.; Walter W. Hamburger, Chicago, and William W. Herrick, New York.

Dr. William N. Bispham, Fort Riley, Kan., read a paper on "The Training of the Medical Officers in the Army." No discussion.

Dr. William H. Robey, Jr., Boston, read a paper on "Neurocirculatory Asthenia." Discussed by Sir James Mackenzie, London, England, and Drs. Louis M. Warfield, Milwaukee; B. S. Oppenheimer, New York; Abraham Jacobi, New York, and William H. Robey, Jr., Boston.

Dr. Joseph H. Pratt, Boston, read a paper on "Newer Aspects of Digitalis Therapy." Discussed by Sir James Mackenzie, London, England.

The following officers were elected: chairman, Dr. Walter L. Bierring, Des Moines, Iowa; vice chairman, Dr. Charles G. Jennings, Detroit; secretary, Dr. James S. McLester, Birmingham, Ala.; delegate, Dr. George D. Head, Minneapolis.

Dr. Horace D. Arnold, Boston, read a paper on "War and Medical Education." No discussion.

FRIDAY, JUNE 14—MORNING

The following papers were read as a symposium on "Pneumonia":

Dr. Arthur A. Small, Chicago: "Unique Findings Gathered from the Observation of Eleven Hundred Cases of Pneumonia in a Base Hospital."

Dr. Joseph L. Miller, Chicago: "An Epidemic of Streptococcus Pneumonia and Empyema at Camp Dodge."

Dr. Willard J. Stone, Toledo, Ohio: "A Clinical Study of Eight Hundred Cases of Pneumonia."

Dr. James G. Cumming, Ann Arbor, Mich.: "Streptococcus Pneumonia."

Dr. William G. MacCallum, Baltimore: "The Pathology of the Pneumonia of the Army Camp."

Dr. Ralph A. Kinsella, St. Louis: "Practical Consideration of Epidemiology Drawn from a Classification of Streptococci."

These papers were discussed by Drs. William H. Welch, Baltimore; Lawrence Litchfield, Pittsburgh; F. F. Russell, Washington, D. C.; Rufus I. Cole, New York; Walter P. Bliss, New York; C. Hugh McKenna, Chicago; George F. Dick, Chicago, and Edward C. Rosenow, Rochester, Minn.

FRIDAY, JUNE 14—AFTERNOON

Dr. Clyde L. Cummer, Cleveland, read a paper on "Later Results of the Intraspinal Treatment of Cerebrospinal Syphilis, Based on Four Years' Observation." Discussed by Dr. John A. Fordyce, New York.

Dr. George H. Lathrope, Morristown, N. J., read a paper on "Relation of Mastoiditis to Acute Infectious Conditions." Discussed by Drs. John B. Potts, Omaha; Arthur A. Small, Chicago; M. E. Scott, Adel, Iowa; Abraham Zingher, New York, and George H. Lathrope, Morristown, N. J.

Dr. Llewellyn Sale, St. Louis, read a paper on "A Study of Diaphragmatic Movements in Acute Abdominal Inflammations." Discussed by Drs. J. B. Guthrie, New Orleans; F. M. Pottenger, Monrovia, Calif.; M. E. Scott, Adel, Iowa; [illegible] N. McDonald, Minneapolis, and Llewellyn Sale, St. Louis.

The paper of Dr. Joseph A. Capps, Chicago, on "The Control of Cross Infections by Masking of Patients," was then read. Discussed by Drs. James S. McLester, Birmingham, Ala.; John Alden Lichty, Pittsburgh; H. P. Greeley, Madison, Wis.; Albert R. Trapp, Springfield, Ill.; Charles H. Lovewell, Chicago; Edward F. Wells, Chicago, and Granville N. Ryan, Des Moines.

SECTION ON SURGERY, GENERAL AND ABDOMINAL

WEDNESDAY, JUNE 12—MORNING

The meeting was called to order at 9:24 by the chairman, Dr. E. Starr Judd, Rochester, Minn.

Dr. Truman W. Brophy, Chicago, read a paper on "Congenital Cleft Palate and Harelip." Discussed by Drs. A. J. Ochsner, Chicago; Arbuthnot Lane, London, England; Charles H. Mayo, Rochester, Minn.; John B. Roberts, Philadelphia, and Truman W. Brophy, Chicago.

The following papers were read as a symposium on "The Thyroid":

Dr. Charles H. Mayo, Rochester, Minn.: "The Principles of Thyroid Surgery."

Dr. Donald Guthrie, Sayre, Pa.: "Temporary Loss of Voice Following Thyroidectomy."

Dr. Edward G. Jones, Atlanta, Ga.: "Goiter in the Southeast."

These three papers were discussed by Drs. Charles N. Dowd, New York; Arbuthnot Lane, London, England; Miles F. Porter, Fort Wayne, Ind.; Rollo C. Dugan, Ottawa, Kan.;

H. J. Stewart, Oak Park, Ill.; J. W. McDonald, Chicago; C. H. Magee, Burlington, Iowa; Edwin P. Sloan, Bloomington, Ill.; John W. Long, Greensboro, N. C.; C. H. Mayo, Rochester, Minn.; Donald Guthrie, Sayre, Pa., and Edward G. Jones, Atlanta, Ga.

Dr. Willy Meyer, New York, read a paper on "Glycophilia." Discussed by Drs. W. S. Schrayer, Chicago, and Willy Meyer, New York.

Dr. Ralph E. Morter, Milwaukee, read a paper on "End-Results in Hodgkin's Diseases." Discussed by Vincent A. Lapenta, Indianapolis; William C. MacCarthy, Rochester, Minn., and Ralph E. Morter, Milwaukee.

Wednesday, June 12—Afternoon

The meeting was called to order at 2:15 by the chairman, Dr. E. Starr Judd, Rochester, Minn.

Dr. Judd read the chairman's address, entitled "The Surgery of the Gallbladder and Biliary Ducts." No discussion.

Dr. J. Shelton Horsley, Richmond, Va., read a paper on "Reconstruction of the Common Duct from the Experimental Standpoint."

Dr. LeGrand Guerry, Columbia, S. C., read a paper on "Clinical Report on Reconstruction of the Common and Hepatic Ducts."

These two papers were discussed by Drs. Arthur G. Sullivan, Madison, Wis.; C. N. Davis, Chicago; L. L. McArthur, Chicago; H. O. Marcy, Boston; I. J. Straus, Chicago, and J. Shelton Horsley, Richmond, Va.

Dr. J. Earl Else, Portland, Ore., read a paper on "Rôle of the Cystic Duct in Recurring Cholecystitis." No discussion.

Dr. Edward W. Archibald, Montreal, read a paper on "The Ultimate Results in Cases of Chronic and Subacute Pancreatitis." Discussed by Drs. W. D. Haggard, Nashville, Tenn.; E. Starr Judd, Rochester, Minn.; J. Earl Else, Portland, Ore.; Rollo C. Dugan, Ottawa, Kan., and Edward W. Archibald, Montreal.

Friday, June 14—Morning

The meeting was called to order at 9:30 by the chairman, Dr. E. Starr Judd, Rochester, Minn.

Dr. Hermann B. Gessner, New Orleans, read a paper on "The Therapeutics of Tetanus." Discussed by Samuel J. Meltzer, New York; A. J. Ochsner, Chicago; W. Estell Lee, Philadelphia; Carl J. Holman, Mankato, Minn.; Clark W. Brooks, Detroit, and Hermann B. Gessner, New Orleans.

The following officers were elected: chairman, Dr. John T. Bottomley, Boston; vice chairman, Dr. LeGrand Guerry, Columbia, S. C.; secretary, Dr. Eugene H. Pool, New York; acting secretary, Dr. George P. Müller, Philadelphia; delegate, Dr. Jabez N. Jackson, Kansas City, Mo.; alternate, Dr. Donald Guthrie, Sayre, Pa.

Dr. W. Estell Lee, Philadelphia, Pa., read a paper on "The Use of Dichloramin-T and Other Antiseptics in War Surgery." Discussed by Drs. Edward H. Ochsner, Chicago; Fenton B. Turck, New York, and Lee W. Estell, Philadelphia.

Dr. Frank G. Nifong, Columbia, Mo., read a paper on "The Hodgen Extension Suspension Splint and Its Exemplification in Both Civil and War Surgery." Discussed by Drs. H. D. Wood, Fayetteville, Ark.; Daniel N. Eisendrath, Chicago; F. Reder, St. Louis; C. W. More, Eveleth, Minn.; E. M. Sanders, Nashville, Tenn., and Frank G. Nifong, Columbia, Mo.

Dr. Howard W. Haggard, New Haven, Conn., read a paper on "The Fall of the Alkaline Reserve Under Surgical Conditions: Its Effects and Prevention." Discussed by Dr. Fenton B. Turck, New York, and Howard W. Haggard, New Haven, Conn.

Friday, June 14—Afternoon

The meeting was called to order at 2:30 by the chairman.

Dr. George N. Kreider, Springfield, Ill., read a paper on "Gastroptosis: Its Cause, Prevention and Cure, with Special Reference to the Duret-Rovsing Operation." Discussed by Drs. Carl E. Black, Jacksonville, Ill.; George P. Müller, Philadelphia, and George N. Kreider, Springfield, Ill.

Dr. Arthur C. Strachauer, Minneapolis, read a paper on "A New Principle in the Surgical Treatment of Brain Tumors." Discussed by Dr. L. L. McArthur, Chicago, and Arthur C. Strachauer, Minneapolis.

Dr. Walter E. Sistrunk, Jr., Rochester, Minn., read a paper on "Kondoléon's Operation." Discussed by Drs. Hubert A. Royster, Raleigh, N. C.; H. B. Gessner, New Orleans; H. R. Decker, Pittsburgh, and Walter E. Sistrunk, Jr., Rochester, Minn.

SECTION ON OBSTETRICS, GYNECOLOGY AND ABDOMINAL SURGERY

Wednesday, June 12—Morning

The section was called to order at 9:30 by the chairman, Dr. Brooke M. Anspach, Philadelphia.

Dr. Anspach read the chairman's address, entitled "Enterostomy and Enterocolostomy in the Treatment of Intestinal Obstruction Following Pelvic Operations."

Dr. Anspach, in the absence of the members of the Executive Committee, appointed temporarily on this committee Drs. C. Jeff Miller, New Orleans; E. E. Montgomery, Philadelphia, and W. P. Manton, Detroit.

Dr. Alfred A. Strauss, Chicago, read a paper on "The Clinical Observations and Results of the Newer Methods of Observations in Congenital Pyloric Stenosis and Gastric and Duodenal Ulcers."

Dr. William D. Haggard, Nashville, read a paper on "Hypertrophic Pyloric Stenosis in Infancy."

These papers were discussed by Drs. Frank X. Walls, Chicago; Weller Van Hook, Chicago; I. A. Abt., Chicago; John W. Keefe, Providence, R. I.; Peter B. Salatich, New Orleans; Alfred A. Strauss, Chicago and William D. Haggard, Nashville.

Dr. Daniel N. Eisendrath, Chicago, read a paper on "The Relation of Anomalies of the Bile Ducts and Blood Vessels to Accidents in Biliary Surgery." Discussed by Drs. William D. Haggard, Nashville, Tenn.; E. E. Montgomery, Philadelphia; J. A. Attridge, Port Huron, Mich., and Daniel N. Eisendrath, Chicago.

Dr. Leigh F. Watson, Chicago, read a paper on "Goiter in Pregnancy." Discussed by Drs. James W. Markoe, New York; Charles H. Mayo, Rochester, Minn., and Leigh F. Watson, Chicago.

Dr. William J. Mayo, Rochester, Minn., contributed a paper on "Secondary Tuberculous Peritonitis." Discussed by Drs. Robert T. Morris, New York; C. A. L. Reed, Cincinnati; Daniel N. Eisendrath, Chicago; Horace G. Wetherill, Denver, and Charles H. Mayo, Rochester, Minn.

Dr. J. Riddle Goffe, New York, read a paper on "Abdominal Visceropexy: An Original Method, with a Report of Cases." Discussed by Drs. C. A. L. Reed, Cincinnati; Nathan Rosewater, Cleveland; William T. Reynolds, Kansas City, Mo.; A. H. Aaron, Buffalo, and J. Riddle Goffe, New York.

Wednesday, June 12—Afternoon

Dr. Ira L. Hill, New York, read a paper on "Extending the Care of Pregnancy." Discussed by Drs. Wilmer Krusen, Philadelphia; J. H. Carstens, Detroit; Otto J. Stein, Chicago, and Ira L. Hill, New York.

Dr. Paul Titus, Pittsburgh, read a paper on "Uterine Inertia; Summary of a Series of Cases." Discussed by Drs. Rudolph W. Holmes, Chicago, and Paul Titus, Pittsburgh.

Dr. George W. Kosmak, New York, read a paper on "The Use and Abuse of Pituitary Solution." Discussed by Drs. J. B. De Lee, Chicago; J. L. Bubis, Cleveland; Jennings C. Litzenberg, Minneapolis; C. S. Bacon, Chicago, and W. P. Manton, Detroit.

Dr. John Young Brown, St. Louis, read a paper on "Pus in the Female Pelvis: A Surgical Retrospect."

Dr. Harry P. Ritchie, St. Paul, read a paper on "Rectal Section for Pelvic Abscess."

These two papers were discussed by Drs. J. H. Carstens, Detroit; E. E. Montgomery, Philadelphia; G. N. Thomas,

El Paso, Texas; James Mather Pfeiffenberger, Alton, Ill.; Horace G. Wetherill, Denver; Peter B. Salatich, New Orleans; Robert T. Morris, New York; John Young Brown, St. Louis, and Harry P. Ritchie, St. Paul.

Dr. W. P. Manton, Detroit, read a paper on "Parotitis Following Induced Abortion in a Case of Pernicious Vomiting in Pregnancy." Discussed by Drs. E. E. Montgomery, Philadelphia; M. E. Klingler, Garrett, Ind.; Stephen E. Tracy, Philadelphia, and W. P. Manton, Detroit.

FRIDAY, JUNE 14—MORNING

Dr. Henry T. Byford, Chicago, was elected temporary chairman in the absence of Dr. Anspach, returned to the service.

Dr. John B. Deaver, Philadelphia, read a paper on "Avoidable Traumatic Abdomen." Discussed by Drs. Stephen E. Tracy, Philadelphia; Peter B. Salatich, New Orleans; Emil Novak, Baltimore; A. E. Walker, Anthony, Kan.; A. P. Butt, Davis, W. Va., and John B. Deaver, Philadelphia.

Dr. Franklin H. Martin, Chicago, spoke on "How Surgeons Can Help Win the War." Discussed by Dr. Alfred A. Strauss, Chicago, and Dr. Franklin H. Martin, Chicago.

Dr. Joseph Rilus Eastman, Indianapolis, read a paper on "The Question of Operation in Abdominal Gunshot Injuries." Discussed by Drs. Daniel N. Eisendrath, Chicago, and John Young Brown, St. Louis.

The following officers were elected: chairman, Dr. Thomas J. Watkins, Chicago; vice chairman, Dr. John W. Keefe, Providence, R. I.; secretary, Dr. Sidney A. Chalfant, Pittsburgh; delegate, Dr. F. F. Simpson, Pittsburgh.

Dr. Ira L. Hill, New York, presented for the consideration of the Section on Obstetrics, Gynecology and Abdominal Surgery a resolution "That the American Medical Association appeal to the U. S. government for the appointment of a national commission for the reduction of mortality in childbirth." This resolution was on motion adopted and referred to the delegate of the section for presentation to the House of Delegates of the American Medical Association for action. (No action by the House of Delegates at the 1918 session.)

Dr. Willard Bartlett, St. Louis, read a paper on "Treatment of Incisional Ventral Hernia by the Transplantation of Fascia Lata." Discussed by Drs. Weller Van Hook, Chicago; Alfred A. Strauss, Chicago; C. H. Magee, Burlington, Iowa; Arthur E. Hertzler, Kansas City, Mo.; Peter B. Salatich, New Orleans; Albert Goldspohn, Chicago; S. E. Williams, Chippewa Falls, Wis.; W. P. Manton, Detroit, and Willard Bartlett, St. Louis.

Dr. John W. Keefe, Providence, R. I., read a paper on "The Use of the Rubber Roll in Abdominal Surgery." Discussed by Drs. Albert Goldspohn, Chicago; Melvin J. Locke, Bellefonte, Pa., and John W. Keefe, Providence, R. I.

Dr. Emil Novak, Baltimore, read a paper on "Infantilism and Other Hypoplastic Conditions of the Uterus." No discussion.

FRIDAY, JUNE 14—AFTERNOON

Dr. Nathaniel R. Mason, Boston, and Dr. Frank C. W. Konrad, Boston, presented a paper on "Paravertebral Anesthesia, with Report of One Hundred Cases." Discussed by Drs. Arthur E. Hertzler, Kansas City, and Dr. Frank C. W. Konrad, Boston.

Dr. Arthur E. Hertzler, Kansas City, Mo., read a paper on "The Pathology of Hemorrhagic Myomas and Their Relation to Sarcoma." Discussed by Drs. Emil Novak, Baltimore; Bertha Van Hoosen, Chicago, and Arthur E. Hertzler, Kansas City, Mo.

Dr. Edward A. Weiss, Pittsburgh, read a paper on "The Radical Treatment of Cancer of the Cervix by Igni Extirpation." Discussed by Drs. Albert Goldspohn, Chicago; George Gellhorn, St. Louis; Louis E. Schmidt, Chicago; Bertha Van Hoosen, Chicago; John W. Keefe, Providence, R. I.; J. A. Pettit, Portland, Ore.; Edward A. Weiss, Pittsburgh, and Henry P. Newman, San Diego.

Dr. George Gellhorn, St. Louis, read a paper on "The Conservation of Ovaries After Hysterectomy, with a New Technic of Extirpation of the Uterus." Discussed by Drs. Henry T. Byford, Chicago; Peter B. Salatich, New Orleans; Henry P. Newman, San Diego; C. H. Magee, Burlington, Iowa; Harvey P. Jack, Hornell, N. Y., and George Gellhorn, St. Louis.

Dr. K. I. Sanes, Pittsburgh, read a paper on "Age of Menopause: Observations Based on Statistical Data of Eight Hundred Menopause Cases." Discussed by Dr. Curtis S. Foster, Pittsburgh.

Dr. Stephen E. Tracy, Philadelphia, read a paper on "Plastic Operations in the Vagina and on the Pelvic Floor." Discussed by Drs. Henry P. Newman, San Diego; Albert Goldspohn, Chicago, and Dr. Stephen E. Tracy, Philadelphia.

SECTION ON OPHTHALMOLOGY

WEDNESDAY, JUNE 12—MORNING

In the absence of the chairman, Dr. Alexander Duane, New York, the vice chairman, F. Phinizy Calhoun, Atlanta, Ga., presided. Dr. Edgar S. Thomson, New York, acted as secretary. The session was called to order at 9:15 by the vice chairman, who made a brief address.

The chairman's address, entitled "How May the Physical Standards of the Service Profitably Be Modified?" was read.

Dr. F. Park Lewis, Buffalo, moved that the section arrange a round table at which certain questions may be propounded and answered.

Dr. Edward Jackson, Denver, moved as a substitute that the pending motion, as well as similar suggestions, be referred to the Executive Committee. Seconded and carried.

Dr. Bulson presented the report on the Knapp Testimonial Fund Committee which, on motion duly made and seconded, was ordered received and filed.

Dr. John E. Weeks, New York, read a paper on "Disciform Keratitis." Discussed by Drs. William Zentmayer, Philadelphia; John Green, Jr., St. Louis; Arthur G. Bennett, Buffalo; Will Walter, Chicago; Edgar S. Thomson, New York; Arthur J. Bedell, Albany, N. Y.; F. Park Lewis, Buffalo; John M. Wheeler, New York; R. H. von Kotsch, Chicago; Jesse S. Wyler, Cincinnati, and John E. Weeks, New York.

Dr. Robert J. Curdy, Kansas City, Mo., read a paper on "The Action of Miotic Drugs on Eyes, with Incomplete Sphincter Iritis." Discussed by Drs. Frank C. Todd, Minneapolis, and Robert J. Curdy, Kansas City, Mo.

Dr. John M. Wheeler, New York, read a paper on "Paralysis of the Sixth Cranial Nerve, Associated with Otitis Media." Discussed by Drs. Walter H. Snyder, Toledo, Ohio; H. H. Stark, El Paso, Texas, and John M. Wheeler, New York.

Dr. Lucien Howe, Buffalo, read a paper on "The Relation of Hereditary Eye Defects to Genetics and Eugenics." Discussed by Drs. Howard H. Newman, Chicago; F. Park Lewis, Buffalo; L. M. Loeb, Chicago; F. G. Stueber, Lima, Ohio, and Lucien Howe, Buffalo.

Dr. William R. Thompson, Fort Worth, Texas, read a paper on "The Rational Etiology and Satisfactory Treatment of Dacryocystitis." Discussed by Drs. Harry W. Woodruff, Joliet, Ill.; John Green, Jr., St. Louis; Arthur E. Prince, Springfield, Ill.; Harold Gifford, Omaha; Melville Black, Denver; G. H. Mundt, Chicago, and William R. Thompson, Fort Worth, Texas.

Dr. Lucien Howe, Buffalo, presented the following resolution:

Resolved, That a committee be appointed by the chair to report what action, if any, should be recommended by this section for the prevention of inherited blindness, this committee to be composed of one ophthalmologist, one professional geneticist and one practitioner, especially conversant with the good and also with the bad effects of sterilization. The members of this committee shall have power to add to their number as they deem advisable.

Dr. Howe moved the adoption of the resolution. Seconded and carried.

Dr. Howe presented the report of the Committee on Collective Investigation Concerning Ocular Muscles and moved

the adoption of the report. On motion, duly seconded and carried, the report was adopted.

WEDNESDAY, JUNE 12—AFTERNOON

Vice Chairman Calhoun called the session to order at 2 o'clock.

The vice chairman announced that the resolution which was introduced by Dr. Lucien Howe at the preceding session called for the appointment of a committee for the prevention of inherited blindness. The chairman stated that this committee should consist of Dr. Howe, as chairman, and Drs. H. H. Laughlin and John A. Reilly, this being with the approval of the Executive Committee.

Dr. T. B. Holloway, Philadelphia, exhibited an instrument demonstrating the various forms of refraction.

Dr. George E. de Schweinitz, Philadelphia, read a paper on "Some Aspects of Military Ophthalmic Surgery."

Dr. William H. Wilder, Chicago, read a paper on "Visual Standards of the U. S. Army."

Dr. Waid E. Carson, Pittsburgh, read a paper on "Visual Standards of the U. S. Navy."

The paper of Dr. Allen Greenwood, Boston, on "The Eyes of the Army," was presented in a short summary by Dr. Hiram Woods, Baltimore.

Dr. Edward Jackson, Denver, read a paper on "Common Changes in Regular Astigmatism and Their Causes." Discussed by Drs. Arthur G. Bennett, Buffalo; William Zentmayer, Philadelphia; Joseph S. Lichtenberg, Kansas City, Mo., and Edward Jackson, Denver.

Dr. Howard S. Clark, Minneapolis, read a paper on "Maculocerebral Degeneration with Dementia." Discussed by Drs. F. Park Lewis, Buffalo; Harold Gifford, Omaha, and Edward J. Bernstein, Detroit.

FRIDAY, JUNE 14—MORNING

The section was called to order at 9:15 by Vice Chairman Calhoun.

The following officers were elected: chairman, Dr. Cassius D. Wescott, Chicago; vice chairman, Dr. Thomas B. Holloway, Philadelphia; secretary, Dr. Edgar S. Thomson, New York; delegate, Dr. Walter B. Lancaster, Boston; alternate, Dr. Edward H. Cary, Dallas, Texas.

Dr. Edward Jackson, Denver, was reelected as a member of the American Board of Ophthalmic Examination, for the term of three years beginning with the expiration of his present term, January 1.

Dr. Thomson, on behalf of the chairman of the committee, read the report of the local chairman of the Committee on Conservation of Vision.

On motion, duly seconded and carried, the report was accepted.

Dr. Hiram Woods, Baltimore, presented the report of the American Board for Ophthalmic Examination.

On motion duly seconded and carried, the report was received and filed.

The report of the Committee on Standardizing Test Cards was presented by Dr. Ewing, on behalf of the chairman, Dr. Jackson.

On motion duly seconded and carried, the report was received and filed.

The Committee on Award of the Knapp Medal had no report to make.

The next order of business was the election of a committee on Award of the Knapp Medal. The following were selected: Drs. W. H. Wilder, Chicago; Walter R. Parker, Detroit, and Arnold Knapp, New York.

In view of the serious illness of Dr. Adolf Alt, an ex-chairman of this section, Dr. Greene moved that the Section on Ophthalmology extend to Dr. Adolf Alt its greetings and best wishes for his speedy restoration to health. Seconded and carried.

Dr. Zentmayer moved that a resolution of sympathy be sent to Dr. Wescott, chairman elect of this section for the ensuing year (Dr. Wescott having been recently operated on and being still in the hospital), the resolution also expressing the wishes of the section for his speedy recovery. Seconded and carried.

Dr. William W. Kahn, Detroit, read a paper on "Pollakiuria or Excessive Frequency of Micturition as a Functional Disturbance Due to Eyestrain." Discussed by Drs. Isaac Hartshorne, New York, and William W. Kahn, Detroit.

Drs. John Green, Jr., and William F. Hardy, St. Louis, presented a paper on "Astigmatism Against the Rule." Discussed by Drs. Walter B. Lancaster, Boston; H. B. Lemere, Omaha; William W. Kahn, Detroit; Clark W. Hawley, Chicago; Edgar S. Thomson, New York, and William F. Hardy, St. Louis.

Dr. James G. Dwyer, New York, read a paper on "Focal Infections of the Eye from the Intestinal Tract." Discussed by Drs. Edgar S. Thomson, New York; Hiram Woods, Baltimore; Harry Gradle, Chicago; Clark W. Hawley, Chicago; Walter B. Lancaster, Boston; Will Walter, Chicago, and James G. Dwyer, New York.

Dr. F. Phinizy Calhoun, Atlanta, Ga., read a paper on "Alterations in the Visual Fields Associated with Pellagra." Discussed by Drs. Edward V. L. Brown, Chicago, and F. Phinizy Calhoun, Atlanta, Ga.

Dr. Edward H. Cary, Dallas, Texas, read a paper on "A Study of the Histology and Pathology of the Superstructure of the Lid Occurring in Trachoma," with motion pictures. Discussed by Drs. Vard H. Hulen, San Francisco; C. H. Dewey, Washington, D. C.; Arthur E. Prince, Springfield, Ill., and Edward H. Cary, Dallas, Texas.

FRIDAY, JUNE 14—AFTERNOON

The section was called to order by the vice chairman.

Dr. Hunter H. Turner, Pittsburgh, read a paper on "The Etiology of Phlyctenular Ophthalmia." Discussed by Drs. Edward B. Heckel, Pittsburgh; Henry E. Goldberger, Chicago, and Hunter H. Turner, Pittsburgh.

Dr. Arthur E. Ewing, St. Louis, read a paper on "Post-ciliary Scleral Trephining for Acute Glaucoma." Discussed by Drs. William F. Hardy, St. Louis, and Arthur E. Ewing, St. Louis.

Dr. Harold Gifford, Omaha, read a paper on "The Treatment of Blood Cysts of the Orbit." The discussion on this paper by Dr. Albert E. Bulson, Fort Wayne, Ind., was read by the secretary owing to the absence of Dr. Bulson. The paper was further discussed by Dr. Harold Gifford, Omaha.

Dr. Melville Black, Denver, read a paper on "The Management of Certain Intractable Lid Conditions." Discussed by Drs. J. S. Clark, Freeport, Ill.; Oliver Tydings, Chicago, and Dr. H. B. Lemere, Omaha.

Dr. Arthur E. Prince, Springfield, Ill., read a paper on "An Operation for Cataract Especially Adapted to Cases of Intractable Sepsis of the Conjunctiva or the Lacrimal Sac."

Drs. William H. Fisher and H. D. Thornburg, Chicago, presented a paper entitled "A Method of Acquiring Cataract Technic Leading to the Smith-Indian Intracapsular."

These two papers were discussed by Drs. Louis D. Green, San Francisco; Vard H. Hulen, San Francisco; Clark W. Hawley, Chicago; John W. Wright, Columbus, Ohio; Lewis K. Beck, San Antonio, Texas; Ira E. Hoffman, Chicago; G. H. Mundt, Chicago; Arthur E. Prince, Springfield, Ill.; H. D. Thornburg, Chicago, and William A. Fisher, Chicago.

SECTION ON LARYNGOLOGY, OTOLOGY AND RHINOLOGY

WEDNESDAY, JUNE 12—MORNING

The section was called to order at 9:20 by the chairman, Dr. Greenfield Sluder, St. Louis.

Dr. Sluder read the chairman's address, entitled "The Specialist's Relation to the American Medical Association." Discussed by Drs. Wendell C. Phillips, New York, and George F. Cott, Buffalo.

The secretary, Dr. L. W. Dean, Iowa City, Iowa, moved that the acting chairman, Dr. Thomas Hubbard, Toledo, Ohio, appoint a committee of three on chairman's address, this committee to report at the Friday morning session. Sec-

onded and carried. The following were appointed: Drs. William B. Chamberlin, Cleveland; George E. Shambaugh, Chicago, and J. A. Stucky, Lexington, Ky.

Dr. Chevalier Jackson, Philadelphia, read a paper on "Acromegaly of the Larynx." Discussed by Drs. William B. Chamberlin, Cleveland, and Chevalier Jackson, Philadelphia.

Dr. Thomas Hubbard, Toledo, Ohio, read a paper on "Certain Traumatic Lesions of the Esophagus." Discussed by Drs. Chevalier Jackson, Philadelphia; George F. Keiper, Lafayette, Ind.; J. A. Stucky, Lexington, Ky.; George F. Cott, Buffalo; William B. Chamberlin, Cleveland; Joseph C. Beck, Chicago; G. C. Kneedler, Pittsburgh; Eugene L. Myers, St. Louis, and Dr. Thomas Hubbard, Toledo, Ohio.

Dr. Wendell C. Phillips, New York, moved that a committee be appointed by the chairman of this section to prepare a statement recommending legislation in regard to the labeling of caustic preparations, and that this appeal be made through the Council on Pharmacy and Chemistry of the American Medical Association. Seconded and carried.

Dr. Hugh T. Patrick, Chicago, read a paper on "Indurative Headaches." Discussed by Drs. George E. Shambaugh, Chicago; H. W. Loeb, St. Louis; Oliver Tydings, Chicago; Arthur M. Corwin, Chicago; Charles D. Thomas, Peoria, Ill., and Hugh T. Patrick, Chicago.

Dr. Joseph W. Charles, St. Louis, read a paper on "Ocular Headaches." Discussed by Drs. William W. Pearson, Des Moines, Iowa; Oscar Wilkinson, Washington, D. C.; Frank Allport, Chicago, and Joseph W. Charles, St. Louis.

WEDNESDAY, JUNE 12—AFTERNOON

The section was called to order at 2:20 by the chairman, Dr. Greenfield Sluder, St. Louis.

Dr. Greenfield Sluder presented a new friction lock for a tonsil guillotine. This can be used without changing the position of the fingers or loosening the grip, and when the guillotine is shut it stays.

Dr. George W. Boot, Chicago, presented a safety pin extractor, in which the point of the pin can be drawn within a spiral.

The chairman then appointed the committee mentioned in Dr. Wendell C. Phillips' motion at the morning session, as follows: Drs. Thomas Hubbard, Toledo, Ohio; Chevalier Jackson, Philadelphia, and Hubert Arrowsmith, Brooklyn.

Dr. Wendell C. Phillips moved that this committee be approved by the section. Seconded and carried.

The paper of Dr. Harris P. Mosher, Lieutenant-Colonel, M. C., N. A., entitled "Informal Report on Activities of Section on Surgery of the Head of Surgeon-General's Office," was read.

Major Norval H. Pierce, Chicago, read a paper on "Otolaryngology in the Army Medical Service."

These two papers were discussed by Drs. Charles W. Richardson, Washington, D. C.; R. H. Fowler, New York; H. W. Loeb, St. Louis; John B. Potts, Omaha, and Norval H. Pierce, Chicago.

The chairman appointed Drs. Elmer L. Kenyon, Chicago; William B. Chamberlin, Cleveland, and Joseph A. Stucky, Lexington, Ky., a committee of three to draft suitable resolutions regarding the war work of the otolaryngologists and ophthalmologists.

The chairman appointed as the Nominating Committee Drs. George F. Cott, Buffalo; George F. Keiper, Lafayette, Ind., and Louis Ostrom, Jr., Rock Island, Ill.

Dr. J. Gordon Wilson, Chicago, read a paper on "Results of Concussion of High Explosive Shells on the Ear." Discussed by Drs. Thomas Hubbard, Toledo, Ohio; Roy W. Dunlap, Tulsa, Okla.; H. W. Loeb, St. Louis; Samuel G. Higgins, Milwaukee, and J. Gordon Wilson, Chicago.

Dr. Joseph A. Stucky, Lexington, Ky., read a paper on "Systemic Factors in the Treatment of Acute and Subacute Sinusitis." Discussed by Drs. George F. Keiper, Lafayette, Ind.; Frank R. Spencer, Boulder, Colo., and Joseph A. Stucky, Lexington, Ky.

The chairman then introduced Dr. Eugene R. Lewis of the Medical Reserve Laboratory, Field No. 1, Mineola, L. I., who gave a short talk on the work being done among the aviators.

FRIDAY, JUNE 14—MORNING

The section was called to order at 9:15 by the secretary, Dr. L. W. Dean, who announced that Dr. Greenfield Sluder had been called home. Dr. George F. Cott, Buffalo, occupied the chair.

The following officers were elected: chairman, Dr. L. W. Dean, Iowa City, Iowa; vice chairman, Dr. Eugene R. Lewis, Mineola, L. I.; secretary, Dr. William B. Chamberlin, Cleveland; delegate, Dr. George F. Keiper, Lafayette, Ind.; alternate, Dr. Frank R. Spencer, Boulder, Colo.

The Committee on Chairman's Address then made its report, which on motion, seconded and carried, was adopted.

The report of the committee to draft resolutions regarding war work was then read and, on motion seconded and carried, was adopted.

The report of the Committee on Necrology was read by Dr. W. B. Chamberlin, Cleveland. But one name was reported this year—Dr. Ephraim Fletcher Ingals, Chicago. On motion, seconded and carried, the report was accepted.

Dr. Warren B. Davis, Philadelphia, read a paper on "Anatomy of the Nasal Accessory Sinuses in Infancy and Childhood." Discussed by Drs. George E. Shambaugh, Chicago; Joseph C. Beck, Chicago; H. A. Canfield, Bradford, Pa., and Warren B. Davis, Philadelphia.

Dr. Henry H. Martin, Savannah, Ga., read a paper on "Treatment of Neuralgia of the Fifth Nerve by Injection of the Gasserian Ganglion." Discussed by Drs. Hugh T. Patrick, Chicago; Joseph C. Beck, Chicago, and Henry H. Martin, Savannah, Ga.

Dr. J. Randolph Page, New York, read a paper on "Anatomy of the Lateral Sinus: Its Connections and Anomalies." Discussed by Drs. George E. Shambaugh, Chicago, and J. Randolph Page, New York.

Dr. Jacob Braun, New York, read a paper on "The Snare-tome Operation for Enucleation of the Tonsil." Discussed by Drs. Frank R. Spencer, Boulder, Colo.; Louis Ostrom, Jr., Rock Island, Ill.; Leon A. Feinstein, St. Louis; Oliver Tydings, Chicago; H. H. Martin, Savannah, Ga.; James A. Watson, Minneapolis, and Jacob Braun, New York.

Dr. J. Leslie Davis, Philadelphia, read a paper on "Diseased Faucial Tonsils: Their Toxic, Infectious and Reflex Effects." Discussed by Dr. George F. Keiper, Lafayette, Ind.

Dr. Thomas W. Moore, Huntington, W. Va., read a paper on "The Present Status of the Operative Treatment of Chronic Frontal Sinusitis." Discussed by Drs. Frank R. Spencer, Boulder, Colo.; George E. Shambaugh, Chicago, and James J. Pattee, Pueblo, Colo.

Dr. Henry B. Lemere, Omaha, read a paper on "The Relation of the Movements of the Head and Eyes to Labyrinth Stimulation." Discussed by Drs. Joseph G. Parsons, Sioux Falls, S. D.; George W. Mackenzie, Philadelphia, and Henry B. Lemere, Omaha.

SECTION ON DISEASES OF CHILDREN

WEDNESDAY, JUNE 12—MORNING

The meeting was called to order at 9:30 by the chairman, Dr. Laurence R. DeBuys, New Orleans.

Owing to the absence of Dr. T. C. McCleave, Oakland, Calif., delegate to the House of Delegates of the American Medical Association, the chairman appointed Dr. H. M. McClanahan, Omaha, to represent the section in the House of Delegates.

Dr. DeBuys read the chairman's address, entitled "Conservation of Child Life, a National Responsibility."

A motion was made by Dr. William Weston, Columbia, S. C., that the chairman appoint a committee of three to confer with the Surgeon-General's Office relative to the status of the pediatric men in this country.

Seconded and carried.

The chairman appointed the following committee: Dr. J. P. Sedgwick, Minneapolis, chairman; Dr. E. C. Fleischner, San Francisco, and William Weston, Columbia, S. C.

Dr. Paul Armand-De Lille, Paris, France, read a paper on "The Infant Mortality Campaign in France."

Dr. William Palmer Lucas, San Francisco, read a paper on "Medical Work Among the Civilian Population in France."

Dr. Grace L. Meigs, Washington, D. C., read a paper on "Children's Year Program for Child Conservation in War Time."

Drs. Julius P. Sedgwick and N. O. Pearce, Minneapolis, presented a paper on "A Report on Children in the War Zone," read by Dr. Pearce.

These papers were discussed by Drs. B. Raymond Hoobler, Detroit; Edgar J. Huenekens, Minneapolis; Lawrence T. Royster, Norfolk, Va.; Joseph I. Grover, Boston; Franklin N. Rogers, Manchester, N. H.; Louis H. Schwartz, New York; John A. Foote, Washington, D. C.; J. T. Christison, St. Paul; Langley Porter, San Francisco; C. F. Wahrer, Fort Madison, Iowa; Frances M. Hollingshead, Columbus, Ohio; Leroy A. Wilkes, Bridgeport, Conn.; E. C. Fleischner, San Francisco; J. P. Sedgwick, Minneapolis; Grace L. Meigs, Washington, D. C.; William Palmer Lucas, San Francisco, and Laurence R. DeBuys, New Orleans.

Wednesday, June 12—Afternoon

The meeting was called to order at 2:30 by the chairman.

Dr. Henry H. Yerington, San Francisco, read a paper on "Clinical Supervision of the Well Baby During Its First Year." Discussed by Drs. C. F. Wahrer, Fort Madison, Iowa, and Louis H. Schwartz, New York.

Dr. Henry J. Gerstenberger, Cleveland, read a paper on "A Report of Three Years' Clinical Experience with the Feeding of S. A. M. (Synthetic Milk Adapted)." Discussed by Drs. C. F. Wahrer, Fort Madison, Iowa; John Zahorsky, St. Louis; Isaac A. Abt, Chicago; Louis H. Schwartz, New York, and Henry J. Gerstenberger, Cleveland.

Dr. Jay I. Durand, Seattle, read a paper on "Digestion of Fat by Gastric and Intestinal Ferment." No discussion.

Dr. Jules M. Brady, St. Louis, read a paper on "Lumbar Puncture in Meningeal Hemorrhage." Discussed by Drs. Frank C. Neff, Kansas City, Mo.; John A. Foote, Washington, D. C.; Lawrence T. Royster, Norfolk, Va., and Jules M. Brady, St. Louis.

Dr. Albert H. Beifield, Iowa City, Iowa, read a paper on "The Significance of Infection of the Accessory Sinuses of the Nose of Infants and Children." Discussed by Drs. R. N. Andrews, Mankato, Minn.; Henry J. Gerstenberger, Cleveland; John Zahorsky, St. Louis; Albert H. Beifield, Iowa City, Iowa, and Paul Armand-De Lille, Paris, France.

Dr. Langley Porter, San Francisco, read a paper on "Chorea." Discussed by Drs. Henry J. Gerstenberger, Cleveland; Henry W. Cheney, Chicago; J. T. Christison, St. Paul, and Langley Porter, San Francisco.

The committee appointed to confer with the Surgeon-Generals made its report.

Dr. E. C. Fleischner presented a resolution to be presented to the War Council as follows:

Resolved, That the War Council of the American Red Cross be asked to appropriate $100,000 for the purpose of better child welfare work, assisting existing organizations working in child welfare work and organizing this work, when approved by the Medical Advisory Board of the American Red Cross. This sum to be expended under the direction of the said committee.

Referred to the House of Delegates with the unanimous approval of those attending the meeting. (See proceedings of the House of Delegates.)

Friday, June 14—Morning

The meeting was called to order at 9:25 by the chairman.

The following officers were elected: chairman, Dr. Frank P. Gengenbach, Denver; vice chairman, Dr. Jay I. Durand, Seattle; secretary, Dr. E. C. Fleischner, San Francisco; delegate, Dr. Isaac A. Abt, Chicago; alternate, Dr. Laurence R. DeBuys, New Orleans.

Dr. Rood Taylor, Rochester, Minn., read a paper on "Treatment of Prematurity." Discussed by Drs. John Zahorsky, St. Louis; Isaac A. Abt, Chicago; Lawrence T. Royster, Norfolk, Va.; Frank C. Neff, Kansas City, Mo.; Jane Merrill Ketcham, Indianapolis; Jules M. Brady, St. Louis; Jay I. Durand, Seattle, and E. J. Huenekens, Minneapolis.

Drs. Harry Lowenburg and A. I. Rubenstone, Philadelphia, presented a paper on "Hemophilia," read by Dr. Lowenburg. Discussed by Drs. C. F. Wahrer, Fort Madison, Iowa; Abraham Jacobi, New York; Rood Taylor, Rochester, Minn., and William Weston, Columbia, S. C.

Dr. Harry M. McClanahan, Omaha, read a paper on "Intestinal Parasites in Children." Discussed by Drs. William Weston, Columbia, S. C.; C. F. Wahrer, Fort Madison, Iowa; A. H. Beifield, Iowa City, Iowa, and Harry M. McClanahan, Omaha.

Dr. Louis Fischer, New York, read a paper on "The Superior Longitudinal Sinus in Infants; Its Value in Transfusion, and for Rapid Medication; Its Adaptability in Procuring Blood for Diagnosis." Discussed by Dr. Harry Lowenburg, Philadelphia.

Dr. William Weston, Columbia, S. C., read a paper on "Purpura Abdominalis in Early Life." Discussed by Drs. John A. Foote, Washington, D. C.; Rood Taylor, Rochester, Minn.; Isaac A. Abt, Chicago; M. L. Turner, Des Moines, Iowa, and William Weston, Columbia, S. C.

Dr. Joseph I. Grover, Boston, read a paper on "Etiology and Treatment of Enuresis." Discussed by Drs. Harry Lowenburg, Philadelphia; H. M. McClanahan, Omaha; M. L. Turner, Des Moines, Iowa; O. W. Rowe, Duluth, Minn.; Franklin N. Rogers, Manchester, N. H., and Joseph I. Grover, Boston.

Dr. Lawrence T. Royster, Norfolk, Va., on behalf of the Executive Committee, presented the name of Dr. Paul Armand-De Lille, Paris, France, for recommendation by this section to honorary membership in the American Medical Association. Unanimously endorsed by the section. (Not transmitted to the House of Delegates in time for action at the 1918 session.)

Friday, June 14—Afternoon

The meeting was called to order at 2:20 by the chairman.

Dr. Edgar J. Huenekens, Minneapolis, read a paper on "Further Report on Pertussis Vaccine Controlled by the Complement Fixation Test." Discussed by Drs. J. T. Christison, St. Paul; Jay I. Durand, Seattle; E. C. Fleischner, San Francisco; Frank C. Neff, Kansas City, Mo., and Edgar J. Huenekens, Minneapolis.

Drs. Emanuel C. Fleischner and K. F. Meyer, San Francisco, presented a paper on "Cutaneous Hypersensitiveness as an Evidence of Infection, and Its Bearing on the Pathogenicity for Infants of the Bacillus Abortus-Bovinus." No discussion.

Dr. John Zahorsky, St. Louis, read a paper on "The Remote Results of Tonsillectomy in the Young." Discussed by Drs. Harry Lowenburg, Philadelphia; Isaac A. Abt, Chicago; E. C. Fleischner, San Francisco; J. P. Sedgwick, Minneapolis, and John Zahorsky, St. Louis.

Dr. Charles E. Hansel, South Bend, Ind., read a paper on "Group Medicine and Pediatrics." Discussed by Drs. R. N. Andrews, Mankato, Minn.; Franklin N. Rogers, Manchester, N. H.; Joseph I. Grover, Boston; O. W. Rowe, Duluth, Minn., and Charles E. Hansel, South Bend, Ind.

Dr. Albert J. Bell, Cincinnati, read a paper on "The Diagnostic Study of Conditions in the Throat Producing Dyspnea." No discussion.

Moved and seconded that Dr. Zahorsky be granted permission to withdraw his paper. Passed.

SECTION ON PHARMACOLOGY AND THERAPEUTICS

Wednesday, June 12—Morning

The Section was called to order at 9:15 by the chairman, Dr. Arthur D. Hirschfelder, Minneapolis. The chairman appointed as the Executive Committee Drs. J. F. Anderson, New Brunswick, N. J.; Torald Sollmann, Cleveland, and C. W. Edwards, Ann Arbor, Mich. The chairman appointed as the nominating committee Drs. Torald Sollmann, Cleveland; Cary Eggleston, New York, and W. A. Puckner, Chicago.

Dr. Hirschfelder read the chairman's address, entitled "The Teaching of Pharmacology." Discussed by Drs. Cary Eggleston, New York; Torald Sollmann, Cleveland; Fred I. Lackenback, San Francisco; Samuel J. Meltzer, New York; Bernard Fantus, Chicago, and Arthur D. Hirschfelder, Minneapolis.

The following papers were read as a symposium on "Activities Bearing on the War."

Dr. Torald Sollmann, Cleveland: "Pharmacology in the War." No discussion.

Dr. Julius Stieglitz, Chicago: "The Problem of Synthetic Drugs." Discussed by Drs. Fred I. Lackenback, San Francisco, and Samuel J. Meltzer, New York.

Dr. Alice Hamilton, Chicago: "Unsolved Problems of Industrial Poisoning in the Making of Explosives." Discussed by Drs. Walter A. Bastedo, New York; Samuel J. Meltzer, New York, and Alice Hamilton, Chicago.

Dr. William Moore, St. Paul, read a paper on "The Chemical Control of Lice." Discussed by Dr. Augustus Wadsworth, Albany, N. Y.

Dr. Bernard Fantus, Chicago, delegate to this section from the American Pharmaceutical Association, addressed the convention, asking its aid toward improving the status of the pharmacist along educational lines. No discussion.

WEDNESDAY, JUNE 12—AFTERNOON

A joint meeting was held with the Section on Pathology and Physiology.

The joint meeting was called to order by the chairman, Dr. Arthur D. Hirschfelder, Minneapolis.

The following papers were read as a symposium on "Diseases Due to Deficiencies in Nutrition":

Dr. E. V. McCollum, Baltimore: "The Vitamin Hypothesis and the Diseases Referable to Faulty Diet."

Dr. Alfred F. Hess, New York: "The Rôle of Antiscorbutics in Our Dietary."

DRS. Joseph Goldberger, G. A. Wheeler and Edgar Sydenstricker, Washington, D. C.: "Diet and Pellagra," read by Dr. Goldberger.

John R. Murlin Washington, D. C.: "Diet of the U. S. Army Soldier," by Dr. R. G. Hoskins, Chicago.

Paul Roth, Battle Creek, Mich.: "Civilian War Rations."

These five papers were discussed by Drs. V. C. Vaughan, Ann Arbor, Mich.; Gideon Wells, Chicago; E. Lyman Fiske, New York; C. W. Green; Joseph Goldberger, Washington, D. C.; Charles W. Greene Columbia, Mo.; John R. Williams, Rochester, N. Y.; E. V. McCollum, Baltimore; E. Lyman Fiske, New York; Ralph G. Mills, Seoul, Korea; William Moore, St. Paul; Arthur D. Hirschfelder, Minneapolis; Alfred F. Hess, New York; R. G. Hoskins, Chicago, and Paul Roth, Battle Creek, Mich.

Dr. Charles F. Hoover, Cleveland, read a paper on "The Therapeutic Indications for the Inhalation of Oxygen." Discussed by Dr. Arthur D. Hirschfelder, Minneapolis.

FRIDAY, JUNE 14—MORNING

The following officers were elected: chairman, Dr. Walter A. Bastedo, New York; vice chairman, G. W. McCoy, Washington, D. C.; secretary, Dr. Cary Eggleston, New York; delegate, Dr. A. D. Hirschfelder, Minneapolis.

A paper on "The Significance of Sounds Heard During the Auditory Measurement of Blood Pressure," by Drs. Clyde Brooks, Pittsburgh, and Albert M. Bleile, Columbus, Ohio, was read by Dr. Arno B. Luckhardt, Chicago. Discussed by Drs. Henry Sewall, Denver; Arthur D. Hirschfelder, Minneapolis, and Arno B. Luckhardt, Chicago.

Dr. E. C. Kendall, Rochester, Minn., read a paper on "The Chemical Groups in the Active Constituent of the Thyroid Which Are Responsible for Its Physiologic Activity." Discussed by Drs. G. M. Jack, Buffalo; V. A. Lapenta, Indianapolis, and E. C. Kendall, Rochester, Minn.

Dr. Jacob Rosenbloom, Pittsburgh, read a paper on "Studies in a Case of Acute Mercuric Chlorid Poisoning Treated by the Newer Methods and Followed by Recovery." Discussed by Drs. Bernard Fantus, Chicago; E. C. Kendall, Rochester, Minn.; Walter A. Bastedo, New York, and J. H. Wilms, Cincinnati.

Dr. E. L. Newcomb, Minneapolis, Minn., read a paper on "Studies on the Valuation of Digitalis." Discussed by Drs. Jacob Rosenbloom, Pittsburgh; Arthur D. Hirschfelder, Minneapolis; Cary Eggleston, New York, and E. L. Newcomb, Minneapolis.

A paper on "Clinical Studies of a Series of Cases Presenting the Phenomena of Cholesteremia," by John R. Williams, Rochester, N. Y., on motion by Dr. Torald Sollmann, seconded by Dr. Cary Eggleston, was referred to the Executive Committee.

SECTION ON PATHOLOGY AND PHYSIOLOGY

WEDNESDAY, JUNE 12—MORNING

The section was called to order at 9:40 by the vice chairman, Dr. Francis Carter Wood, New York.

Dr. Louis B. Wilson, Rochester, Minn., chairman, was not present to read the chairman's address, entitled "Necropsies in American Hospitals." It was announced that he is remaining in France. The vice chairman delivered a brief address, referring to conversations had with the chairman regarding necropsies.

Dr. Carl C. Warden, Ann Arbor, Mich., read a paper on "The Function of Fats in Immune Reactions." Discussed by Drs. Augustus B. Wadsworth, Albany, N. Y.; Francis Carter Wood, New York; Henry Sewall, Denver, and R. B. H. Gradwohl, St. Louis.

Dr. R. B. H. Gradwohl, St. Louis, read a paper on "A New Method of Making the Gonorrheal Complement Fixation Test." Discussed by Drs. Augustus B. Wadsworth, Albany, N. Y.; J. J. Moore, Chicago; J. J. Seelman, Milwaukee, and Carl C. Warden, Ann Arbor, Mich.

Dr. V. H. Moon, Indianapolis, read a paper on "A Further Consideration of Complement Fixation in Tuberculosis." Discussed by Drs. Augustus B. Wadsworth, Albany, N. Y.; Stella M. Gardner, Chicago; J. J. Seelman, Milwaukee; H. J. Corper, Chicago; R. B. H. Gradwohl, St. Louis, and Carl C. Warden, Ann Arbor, Mich.

WEDNESDAY, JUNE 12—AFTERNOON

A joint meeting was held with the Section on Pharmacology and Therapeutics. For a report of the proceedings, see the minutes of that section.

FRIDAY, JUNE 14—MORNING

The following officers were elected: chairman, Dr. Francis Carter Wood, New York; vice chairman, Dr. Isabella C. Herb, Chicago; secretary, Dr. J. J. Moore, Chicago; delegate, Dr. E. R. Le Count, Chicago; alternate, Dr. Howard T. Karsner, Cleveland; executive committee, Drs. Louis B. Wilson, Rochester, Minn.; F. P. Gay, Berkeley, Calif. and James Ewing, New York.

Dr. B. G. R. Williams, Paris, Ill., read a paper on "Some Observations on the Pathology of the Urine in Arteriosclerotic Kidney." No discussion.

Dr. Frank C. Mann, Rochester, Minn., read a paper on "A Further Experimental Study on Surgical Shock." Discussed by Drs. S. J. Meltzer, New York, and Isabella C. Herb, Chicago.

Dr. Henry Albert, Iowa City, Iowa, read a paper on "The Resistance of Streptococci to Germicidal Agents." Discussed by Dr. Fenton B. Turck, New York.

SECTION ON STOMATOLOGY

WEDNESDAY, JUNE 12—MORNING

The meeting was called to order by the chairman, Dr. Frederick B. Noyes, Chicago.

The chairman of the executive committee, Dr. William C. Fisher, New York, submitted the following names of applicants for Associate Fellowship as having been approved by the executive committee:

Brooks, Earl, Noblesville, Ind
Caughron, John R., 434 Lee Bldg., Oklahoma City.
Goldberg, Harry A., 2 W. 86th St., New York.
Hardy, Charles S., 364 Springfield Ave., Summit, N. J.
Lockwood, Bradley F., Yankton, S. D.
Perry, King S., 719 Jenkins Bldg., Pittsburgh.
Preston, S., 504 McBain Bldg., Roanoke, Va.
Rion, C. L., Cobb Bldg., Seattle, Wash.
Sears, Blake A., 847 Main St., Hartford, Conn.
Singleton, Dickson L., First National Bank Bldg., Pittsburgh.
Webster, Fred W., 209 Richard Block, Lincoln, Neb.
Williams, Daniel B., 76 W. Northampton St., Wilkes-Barre, Pa.
Brown, Walter A., 328 Investment Bldg., Pomona, Calif.
Harrison, Guy R., Professional Bldg., Richmond, Va.
Hewitt, W. Stirling, 15th and Locust Sts., Philadelphia.
Jaquette, William A., 235 S. 15th St., Philadelphia.
Lotz, Harry Franklin, Joliet, Ill.
McLean, David W., Mt. Vernon, N. Y.
King, Otto W., Huntington, Ind.
West, George N., Chicago.
Bowles, Shirley W., 1616 I St. N. W., Washington, D. C.
Newton, Thomas G., Northwestern University Dental School, Chicago.

Dr. D. L. Singleton, Pittsburgh, was recommended by the section in 1916, but through some error his name was never presented to the House of Delegates.

It was moved by Dr. Arthur Zentler, New York, and seconded by Dr. E. S. Talbot, Chicago, that these applicants be approved. Motion carried.

Dr. W. C. Fisher, New York, then moved that the additional names that the executive committee is at this time unable to pass on be carried over until next year. Seconded by Dr. Arthur Zentler. Motion carried.

Dr. William C. Fisher, New York, brought up the following matter:

WHEREAS, In our hospitals and dispensaries we have many doctors of German and Austrian birth who have taken out no papers at all or only the first papers of American citizenship, be it

Resolved, That these men be dropped from the staffs of such hospitals and dispensaries for the period of the war.

(Not adopted by the House of Delegates but left to the several hospitals for such action as they consider best.)

Dr. Arthur Zentler moved that it be adopted by the section, seconded and carried.

Seconded and carried as amended.

Dr. Frederick B. Noyes, Chicago, read the chairman's address, entitled "Dental Lymphatic Vessels." Discussed by Drs. E. S. Talbot, Chicago; E. H. Hatton, Chicago; H. A. Potts, Chicago, and F. B. Noyes, Chicago.

Dr. William L. Clark, Philadelphia, read a paper on "An Analysis of Two Hundred Cases of Malignant Discase in the Oral Cavity Treated by Electrothermic Methods, or in Combination with Operative Surgery, Roentgen Rays or Radium."

Dr. Gordon B. New, Rochester, Minn., read a paper on "Treatment of Epithelioma of the Jaws and Cheeks, with Heat and Radium."

These two papers were discussed by Drs. A. J. Ochsner, Chicago; Bertha Van Hoosen, Chicago; Robert Abbe, New York; William L. Clark, Philadelphia, and Gordon B. New, Rochester, Minn.

The chairman appointed as a nominating committee, Drs. T. L. Gilmer, Chicago; R. H. Ivy, Philadelphia, and F. B. Moorehead, Chicago.

WEDNESDAY, JUNE 12—AFTERNOON

The meeting was called to order by the chairman, Dr. Frederick B. Noyes, Chicago.

Dr. Kaethe W. Dewey, Chicago, read a paper on "The Lipoids of Tumors of the Dental System." Discussed by Drs. E. H. Hatton, Chicago, Georgine Luders, Rochester, Minn.; Vida Latham, Chicago; F. B. Moorehead, Chicago, and Kaethe W. Dewey, Chicago.

Dr. Eugene S. Talbot, Chicago, read a paper on "The Genesis of Nasmyth's Membrane, the Epithelial Débris in the Peridental Membrane, and the Granular Layer of Tomes." Discussed by Drs. F. B. Noyes, Chicago; E. H. Hatton, Chicago; Martin Dewey, Chicago, and E. S. Talbot, Chicago.

Dr. Robert H. Ivy, Philadelphia, read a paper on "War Surgery." Discussed by Drs. F. B. Moorehead, Chicago; F. B. Noyes, Chicago; E. S. Talbot, Chicago, and R. H. Ivy, Philadelphia.

FRIDAY, JUNE 14—MORNING

The meeting was called to order by the chairman, Dr. Frederick B. Noyes, Chicago.

The following officers were elected: chairman, Dr. Eugene S. Talbot, Chicago; vice chairman, Chalmers J. Lyon, Ann Arbor, Mich.; secretary, Dr. Arthur D. Black, Chicago; delegate, Dr. William C. Fisher, New York; alternate, Dr. Robert H. Ivy, Philadelphia.

Dr. T. L. Gilmer, Chicago: Just a word about our present secretary, Dr. Talbot. Dr. Talbot has been a member of this section ever since it was organized, and indeed he is one of the men who have helped to make this organization. He has worked very faithfully for all these thirty-eight years. He has always been there. There has never been any one in the section who has done one hundredth part of the work he has done. There has never been any one who has had at heart the interest of the section as Dr. Talbot has had. There is no one who has not conscientiously believed that dentistry is a part of medicine and that we ought to have a branch or section in the American Medical Association, and it is through the efforts of Dr. Talbot and a number of others that we have this section. We feel that maybe he has done a great deal more than had been expected of any one else. We feel that we cannot honor him but we want to honor the section by making him chairman this year. We will never have a better secretary, but he cannot always work and slave as he has in the past. I want to move a vote of thanks and appreciation of the wonderful work and fidelity of our secretary, Dr. E. S. Talbot.

A rising vote of thanks was given to Dr. Talbot for his work as secretary.

Dr. W. C. Fisher, New York, moved that a committee of two with Dr. T. L. Gilmer, Chicago, as chairman, be appointed to draw up a letter to be presented to Dr. Talbot at the next meeting when he takes the chair. Seconded and carried.

Dr. Edward H. Hatton, Chicago, read a paper on "Microscopic Studies of Diseased Peridental Tissues." Discussed by Drs. A. D. Black, Chicago; E. S. Talbot, Chicago; V. H. Moon, Indianapolis; F. B. Noyes, Chicago; F. B. Moorehead, Chicago, and E. H. Hatton, Chicago.

Dr. Arthur D. Black, Chicago, read a paper on "Additional Roentgenographic Studies of Infections of the Maxillary Bones." Discussed by Drs. E. S. Talbot, Chicago; T. L. Gilmer, Chicago; Arthur Zentler, New York; F. B. Moorehead, Chicago; Chalmers J. Lyons, Ann Arbor, Mich.; William C. Fisher, New York, and Arthur D. Black, Chicago.

FRIDAY, JUNE 14—AFTERNOON

The meeting was called to order by the chairman, Dr. Frederick B. Noyes, Chicago.

Dr. Arthur Zentler, New York, read a paper on "A New Surgical Procedure for Operating in Cases of Suppurative Gingivitis, with Alveolar Involvement." Discussed by Dr. George Edward Fell, New York; Thomas L. Gilmer, Chicago; Arthur D. Black, Chicago; Truman W. Brophy, Chicago; Frederick B. Moorehead, Chicago; E. S. Fuller, Dayton, Ohio, and Dr. Arthur Zentler, New York.

Dr. Chalmers J. Lyons, Ann Arbor, Mich., read a paper on "Fractures and Dislocations of the Jaws." Discussed by Drs. Thomas L. Gilmer, Chicago; Truman W. Brophy, Chicago; Arthur D. Black, Chicago; John E. Nyman, Chicago; Arthur Zentler, New York; A. W. McCullough, Pittsburgh; Frederick B. Moorehead, Chicago, and Chalmers J. Lyons, Ann Arbor, Mich.

Dr. Vida Latham, Chicago, read a paper on "Fractures of the Bones of the Face, with Complication." Discussed by Drs. Bertha Bush, Chicago; Arthur Zentler, Chicago, and Vida Latham, Chicago.

Dr. George Edward Fell, Chicago, read a paper on "Sectional Views of the Accessory Sinuses of the Human Cranium." Discussed by Drs. William Brown, Oak Park, Ill., and Dr. George Edward Fell, Chicago.

SECTION ON NERVOUS AND MENTAL DISEASES

WEDNESDAY, JUNE 12—MORNING

The meeting was called to order by the chairman, Dr. C. Eugene Riggs, St. Paul.

Dr. C. Eugene Riggs, St. Paul, read the chairman's address, entitled "Some Further Considerations Concerning the Treatment of Neurosyphilis."

On motion, the section declared it to be its opinion that the minimum number of units should not be less than four, and the total number of papers to be presented in the four sessions not less than twenty-five.

The chairman appointed the following members to act as a nominating committee: Drs. James H. McBride, Pasadena, Calif.; Philip Zenner, Cincinnati, and Harold N. Moyer, Chicago.

Dr. Albert E. Sterne, Indianapolis, read a paper on "The Interpretation of Negative Laboratory Findings in Syphilis, with Special Reference to Treatment." Discussed by Drs. C. R. Ball, St. Paul; Julius Grinker, Chicago; Walter Timme, New York; Elmer E. Southard, Boston; A. L. Skoog, Kansas City, Mo.; Frank P. Norbury, Jacksonville, Ill.; Francis X. Dercum, Philadelphia; G. A. Moleen, Denver; Otto G. Freyermuth, San Francisco; Tom B. Throckmorton, Des Moines; Walter F. Schaller, San Francisco; Joseph Byrne, New York; Joseph M. Aikin, Omaha, and Albert E. Sterne, Indianapolis.

In the absence of Dr. Bernard Sachs, New York, the chairman appointed Dr. Walter Timme, New York, to act on the Executive Committee.

Dr. Elmer E. Southard, Boston, read a paper on "Insanity versus Mental Disease; Duty of the General Practitioner in Psychiatric Diagnosis." No discussion.

Dr. William A. Jones, Minneapolis, read a paper on "Cerebral Edema Due to Pressure." Discussed by Drs. Frank P. Norbury, Jacksonville, Ill.; A. L. Skoog, Kansas City, Mo.; Albert E. Sterne, Indianapolis; Joseph Byrne, New York; Bayard Holmes, Chicago, and William A. Jones, Minneapolis.

Dr. Charles W. Hitchcock, Detroit, read a paper on "Carbon Monoxid Poisoning, with Report of a Case: Its Nervous and Mental Symptoms." Discussed by Drs. Joseph Byrne, New York; G. A. Moleen, Denver, and Charles W. Hitchcock, Detroit.

Dr. Francis X. Dercum, Philadelphia, read a paper on "The Visceral Symptomatology of Nervous Diseases." Discussed by Drs. Theodore Diller, Pittsburgh; Walter Timme, New York; William A. Jones, Minneapolis; Joseph Byrne, New York; C. R. Ball, St. Paul; Albert E. Sterne, Indianapolis; Otto G. Freyermuth, San Francisco; B. Lemchen, Dunning, Ill., and Francis X. Dercum, Philadelphia.

Dr. Hugh T. Patrick, Chicago, reported that a movement had been started with a view to publishing, under the auspices of the American Medical Association, a journal devoted to neurology and psychiatry, and that at the last meeting of the American Neurological Association it was suggested that a petition signed by the neurologists and psychiatrists of the United States and Canada be presented to the trustees of the Association earnestly requesting that they establish a journal of neurology and psychiatry under a plan similar to that under which the *Archives of Internal Medicine* is published. Dr. Patrick said that the petition had already been signed by over fifty neurologists and that other endorsements had been received by mail, and expressed the hope that any members of the section who had not as yet signed the petition would do so.

Dr. Theodore Diller, Pittsburgh, moved that the section give its endorsement to the project as outlined, and that Dr. Patrick be requested to see Dr. George H. Simmons, editor of THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, and inform him to this effect; also that he invite additional signatures to this petition. Seconded and carried.

WEDNESDAY, JUNE 12—AFTERNOON

Dr. Lewellys F. Barker, Baltimore, read a paper on "Nervous and Mental Symptoms in Exophthalmic Goiter." Discussed by Drs. Joseph Byrne, New York, and F. M. Pottenger, Monrovia, Calif.

Dr. Beverley R. Tucker, Richmond, Va., read a paper on "Pituitary Disturbance in Relation to the Psychoses of Adolescence." Discussed by Dr. Archibald Church, Chicago.

Dr. L. Pierce Clark, New York, read a paper on "Some Suggestions for More Accurate Mental Therapy in Epilepsy." Discussed by Drs. Archibald Church, Chicago; Meyer Solomon, Chicago; Joseph Byrne, New York, and L. Pierce Clark, New York.

Dr. Andrew L. Skoog, Kansas City, Mo., read a paper on "Pineal Gland Neoplasms, with Report of a Case Studied Clinically and Pathologically." Discussed by Drs. Beverley R. Tucker, Richmond, Va., and Andrew L. Skoog, Kansas City, Mo.

Dr. Walter F. Schaller, San Francisco, read a paper on "Prognosis in Traumatic Neurosis." Discussed by Drs. Francis X. Dercum, Philadelphia; Andrew L. Skoog, Kansas City, Mo.; Francis A. Ely, Des Moines, Iowa; Julius Grinker, Chicago; Edmund Jacobson, Chicago; C. R. Ball, St. Paul; Elmer E. Southard, Boston; G. A. Moleen, Denver; Theodore Diller, Pittsburgh; Meyer Solomon, Chicago; William A. Jones, Minneapolis; Walter Timme, New York; Charles W. Hitchcock, Detroit; Albert E. Sterne, Indianapolis; Alberta F. Moffet Greene, Kansas City, Mo., and Walter F. Schaller, San Francisco.

Dr. Frank P. Norbury, Jacksonville, Ill., read a paper on "Treatment of Toxic and Exhaustion Psychoses." Discussed by Drs. Theodore Diller, Pittsburgh; Meyer Solomon, Chicago; C. R. Woodson, St. Joseph, Mo., and Frank P. Norbury, Jacksonville, Ill.

Dr. Otto G. Freyermuth, San Francisco, read a paper on "Posterior Column Lesions Nonspecific." No discussion.

FRIDAY, JUNE 14—MORNING

The following officers were elected: chairman, Dr. Archibald Church, Chicago; vice chairman, E. E. Southard, Boston; secretary, Charles W. Hitchcock, Detroit; delegate, Hugh T. Patrick, Chicago; alternate, W. A. Jones, Minneapolis.

Dr. Richard H. Hutchings, Major, M. R. C., U. S. Army, representative of the Office of the Surgeon-General, U. S. Army, read a paper on "Neuropsychiatry and the Mobilization." Discussed by Drs. G. A. Moleen, Denver; Alberta F. Moffet Greene, Kansas City, Mo.; Edward E. Mayer, Pittsburgh; C. R. Ball, St. Paul; Andrew W. Hoisholt, Napa, Calif.; Frank P. Norbury, Jacksonville, Ill.; H. I. Davis, Chicago; Peter Bassoe, Chicago; Lesser Kauffman, Buffalo; G. W. Hall, Chicago, and Richard H. Hutchings, Washington, D. C.

Dr. Walter Timme, New York, read a paper on "The Neuropsychiatric Personnel: The Character and Make-Up of the Members of the Neuropsychiatric Division of the Medical Reserve Corps." Discussed by Drs. Frank P. Norbury, Jacksonville, Ill.; Joseph Byrne, New York, and Walter Timme, New York.

Dr. Lawrence B. Pilsbury, Lincoln, Neb., read a paper on "The Personal Equation in Psychiatry." Discussed by Drs. William O. Krohn, Chicago; Joseph Byrne, New York; Albert E. Sterne, Indianapolis; Harold N. Moyer, Chicago; Beverley R. Tucker, Richmond, Va., and Lawrence B. Pilsbury, Lincoln, Neb.

Dr. H. Douglas Singer, Kankakee, Ill., read a paper on "The Medical Practitioner and Mental Hygiene." Discussed by Drs. Meyer Solomon, Chicago; Joseph Byrne, New York; Hugh T. Patrick, Chicago; Lulu Hunt Peters, Los Angeles; William O. Krohn, Chicago; Edward E. Mayer, Pittsburgh; C. R. Ball, St. Paul, and H. Douglas Singer, Kankakee, Ill.

Dr. Edward E. Mayer, Pittsburgh, read a paper on "Radiculitis: Its Diagnosis and Interpretation." Discussed by Drs. William A. Jones, Minneapolis; G. A. Moleen, Denver; Joseph Byrne, New York, and Edward E. Mayer, Pittsburgh.

Dr. I. Leon Meyers, Chicago, read a paper on "The Cerebellar Gait: A Pedographic Study." No discussion.

Dr. Julius Grinker, Chicago, moved that the section extend a vote of thanks to the outgoing officers, and particularly

to Secretary Hamilton, who has handled the work connected with his office during the past three years. Dr. Albert E. Sterne, Indianapolis, seconded the motion, and it was carried by rising vote.

Dr. William A. Jones, Minneapolis, said: In view of the work contributed by the medical profession, both at its annual meetings and through the efforts of the men directly connected with war activities, I move that the Transportation Committee of the American Medical Association be requested to secure reduced railroad rates to members of the Association, and particularly to those who live at a distance, and that this motion be transmitted to the secretary of the American Medical Association through the secretary of this section.

Dr. Lesser Kauffman, Buffalo, seconded this motion, which was unanimously carried.

With reference to the paper entitled "A Psychiatric Contribution to the Problem of Prison Reform," by Dr. Herman M. Adler, Chicago, it was moved by Dr. C. Eugene Riggs, St. Paul, that because of the lateness of the hour, and in view of the fact that the author was present, the paper be read by title and passed. Seconded and carried.

SECTION ON DERMATOLOGY

WEDNESDAY, JUNE 12—MORNING

The meeting was called to order at 9:30 by the chairman, Dr. Henry H. Hazen, Washington, D. C.

The chairman appointed Dr. Ernest D. Chipman, San Francisco, to serve on the Executive Committee in the place of Dr. Howard Fox, New York, who was in active service with the Medical Reserve Corps.

Dr. Henry H. Hazen, Washington, D. C., read the chairman's address, entitled "The Duties of the Dermatologist."

The following papers were read as a symposium on "Skin Tuberculosis."

Dr. Fred Wise, New York, read the paper submitted by Dr. Sigmund S. Pollitzer, New York, on "Cutaneous Tuberculosis: a Survey."

Dr. Fred Wise, New York: "Miliary Tuberculosis of the Skin, Lichen Scrofulosum and Papulonecrotic Tuberculids."

Drs. Samuel E. Sweitzer and Henry E. Michelsen, Minneapolis: "Sarcoids and Erythema Induratum of Bazin."

Drs. John E. Lane, New Haven, Conn., and Max Scheer, New York: "Dermatoses Possibly Related to Tuberculosis."

These four papers were discussed by Drs. Joseph Zeisler, Chicago; Richard L. Sutton, Kansas City, Mo.; John A. Fordyce, New York; J. H. Stokes, Rochester, Minn.; Frederick G. Harris, Chicago; Augustus Ravogli, Cincinnati; Walter J. Heimann, New York; Everett S. Lain, Oklahoma City; Ernest D. Chipman, San Francisco; Moses Scholtz, Cincinnati; Fred Wise, New York; John E. Lane, New Haven, Conn., and Henry E. Michelsen, Minneapolis.

Dr. Meyer L. Heidingsfeld, Cincinnati, read a paper on "The Too Intensive Arsphenamin (Salvarsan) Treatment of Syphilis." Discussed by Drs. John H. Fordyce, New York; Budd C. Corbus, Chicago; J. H. McBride, Kansas City, Mo.; John E. Lane, New Haven, Conn.; Richard L. Sutton, Kansas City, Mo.; King Smith, Toronto; E. J. Trowe, Toronto; Fred Wise, New York; Joseph Zeisler, Chicago; Bernard Erdman, Indianapolis; Arthur W. Stillians, Chicago; Walter J. Heimann, New York; Henry R. Varney, Detroit, and Meyer L. Heidingsfeld, Cincinnati.

The chairman appointed the following nominating committee: Drs. John E. Lane, New Haven, Conn., Henry R. Varney, Detroit, and J. B. Shelmire, Dallas, Texas.

WEDNESDAY, JUNE 12—AFTERNOON

The meeting was called to order at 2:30 by the chairman, Dr. Henry H. Hazen, Washington, D. C.

The following papers were read as a symposium on "Syphilis in Its Economic Aspects."

Drs. Wade H. Brown and Louise Pearce, New York: "Experimental Therapy in Syphilis."

Dr. William Allen Pusey, Chicago: "The Handling of the Venereal Disease Problem in the Army at the Present Time."

Dr. John A. Fordyce, New York: "The Value of Early Diagnosis and Immediate Treatment in Preventing Neurosyphilis; Its Economic Aspects."

Dr. Harry G. Irvine, Minneapolis: "Syphilis and Venereal Diseases as a Public Health Problem."

These four papers were discussed by Drs. John E. Lane, New Haven, Conn.; John H. Stokes, Rochester, Minn.; King Smith, Toronto; Abram Schuyler Clark, New York; Fred Wise, New York; James Herbert Mitchell, Chicago; Loyd Thompson, Hot Springs, Ark.; Moses Scholtz, Cincinnati; A. H. Martin, Hot Springs, Ark.; Frank Wright, Minneapolis; Walter J. Heimann, New York; Wade H. Brown, New York; William Allen Pusey, Chicago; John H. Fordyce, New York, and Harry G. Irvine, Minneapolis.

FRIDAY, JUNE 14—MORNING

The meeting was called to order at 9:30 by the chairman, Dr. Henry H. Hazen, Washington, D. C.

The following officers were elected: chairman, Dr. Otto H. Foerster, Milwaukee; vice chairman, Dr. David Lieberthal, Chicago; secretary, Dr. Walter J. Heimann, New York; delegate, Dr. George MacKee, New York; alternate, Dr. Fred Wise, New York.

The following papers were read as a symposium on "Bullous Dermatoses."

Dr. Walter J. Heimann, New York: "Pemphigus: a Clinical Study."

Dr. David Lieberthal, Chicago: "Toxic and Bullous Drug Eruptions and the Bullous Erythemas."

These two papers were discussed by Drs. Henry H. Hazen, Washington, D. C.; Richard L. Sutton, Kansas City, Mo.; Augustus Ravogli, Cincinnati; John A. Fordyce, New York; Michael L. Ravitch, Louisville, Ky.; Harry G. Irvine, Minneapolis; Jesse B. Shelmire, Dallas, Texas; Philip Frank Shaffner, Chicago; Samuel E. Sweitzer, Minneapolis; Everett S. Lain, Oklahoma City; Moses Scholtz, Cincinnati; Joseph Zeisler, Chicago; Walter J. Heimann, New York, and David Lieberthal, Chicago.

Dr. Lloyd W. Ketron, Baltimore, read a paper on "Unusual Forms of Epitheliomas of the Skin." Discussed by Drs. Henry H. Hazen, Washington, D. C.; Frederick G. Harris, Chicago; Richard L. Sutton, Kansas City, Mo.; Augustus Ravogli, Cincinnati; L. B. Mount, Albany, N. Y.; K. A. Zurawski, Chicago, and Lloyd W. Ketron, Baltimore.

Dr. Michael L. Ravitch, Louisville, Ky., read a paper on "Further Observations Concerning Dermatoses Attributed to Focal Infections."

Dr. Ernest Dwight Chipman, San Francisco, read a paper on "The Etiology of Lichen Planus."

These two papers were discussed by Drs. Richard L. Sutton, Kansas City, Mo.; King Smith, Toronto; John E. Lane, New Haven, Conn.; Frederick G. Harris, Chicago; Moses Scholtz, Cincinnati; Everett S. Lain, Oklahoma City; David Lieberthal, Chicago; J. S. Eisenstaedt, Chicago; K. A. Zurawski, Chicago; J. H. Stokes, Rocheser, Minn.; Henry H. Hazen, Washington, D. C.; Michael L. Ravitch, Louisville, Ky., and Ernest Dwight Chipman, San Francisco.

FRIDAY, JUNE 14—AFTERNOON

The meeting was called to order at 2:30 by the chairman, Dr. Henry H. Hazen, Washington, D. C.

Dr. Edward H. Reede, Washington, D. C., read a paper on "The Rôle of the Vegetative Nervous System in Certain Diseases of the Skin." Discussed by Drs. Ernest L. McEwen, Chicago; William Allen Pusey, Chicago; Richard L. Sutton, Kansas City, Mo.; Henry J. Gerstenberger, Cleveland; J. H. Stokes, Rochester, Minn.; Loretta Joy Cummins, Boston; Augustus Ravogli, Cincinnati; B. W. Eppler, Kalamazoo, Mich.; Henry H. Hazen, Washington, D. C.; Edward H. Reede, Washington, D. C.

Drs. Richard L. Sutton, Kansas City, Mo., and Frank E. Simpson, Chicago, presented a paper on "Retention Cysts of the Mucous Membrane of the Lip." Discussed by Drs. William Allen Pusey, Chicago, and Jesse B. Shelmire, Dallas, Texas.

Drs. Jesse B. Shelmire, and James H. Black, Dallas, Texas, presented a paper on "Adenoma Sebaceum: Report

of Five Cases in One Family." Discussed by Drs. James Herbert Mitchell, Chicago; Richard L. Sutton, Kansas City, Mo., and Jesse B. Shelmire, Dallas, Texas.

Dr. Everett S. Lain, Oklahoma City, read a paper on "Dermatitis Lycopersicum Esculentum." Discussed by Drs. Arthur W. Stillians, Chicago; J. Frank Waugh, Chicago; Ernest L. McEwen, Chicago; Frederick G. Harris, Chicago; David Lieberthal, Chicago; Richard L. Sutton, Kansas City, Mo.; Robert G. Washburn, Milwaukee; Harold N. Cole, Cleveland; James Herbert Mitchell, Chicago; John E. Lane, New Haven, Conn.; William Allen Pusey, Chicago, and Everett S. Lain, Oklahoma City.

Dr. J. S. Eisenstaedt, Chicago, read a paper on "A Case of Sporotrichosis Resembling Tuberculosis of the Skin." Discussed by Drs. Frederick G. Harris, Chicago; K. A. Zurawski, Chicago; Richard L. Sutton, Kansas City, Mo.; Augustus Ravogli, Cincinnati, and J. S. Eisenstaedt, Chicago.

The newly elected officers were inducted into office and made brief and appropriate speeches of acceptance.

SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

WEDNESDAY, JUNE 12—MORNING

The meeting was called to order at 9:30 by the chairman, Dr. W. S. Rankin, Raleigh, N. C.

The following papers were read as a symposium on "Rural Sanitation":

Dr. W. S. Rankin, Raleigh, N. C.: "Coordinate Responsibility of Nation, State and County in Rural Sanitation." Discussed by Drs. J. W. Schereschewsky, Washington, D. C.; H. B. Hemenway, Springfield, Ill.; Otto P. Geier, Cincinnati; John N. Hurty, Indianapolis; James A. Hayne, Columbia, S. C., and W. S. Rankin, Raleigh, N. C.

Dr. John N. Hurty, Indianapolis: "State Responsibility and Aims in County Health Work." Discussed by Dr. Réné Sand of the Belgian Mission, on Industrial Management, Mr. F. L. Hoffman, Newark, N. J., and Dr. James A. Hayne, Columbia, S. C.

Dr. Otto P. Geier, Cincinnati, by request, made a statement on "Industrial Hygiene." Discussed by Dr. W. A. Evans, Chicago; Dr. J. W. Schereschewsky, Washington, D. C.; Major Edouard Rist, of the French Mission; Dr. William H. Welch, Lieutenant-Colonel, M. C., N. A.; Dr. Victor C. Vaughan, Colonel, M. C., N. A., and Dr. Oscar Dowling, Shreveport, La.

The following nominating committee was appointed: Dr. E. R. Kelley, Boston; Dr. Otto P. Geier, Cincinnati, and Dr. Oscar Dowling, Shreveport.

Dr. S. W. Welch, Montgomery, Ala., presented a resolution with reference to maintaining the working efficiency of the state boards of health of the several states.

The resolution was adopted.

WEDNESDAY, JUNE 12—AFTERNOON

A joint meeting was held with the Section on Orthopedic Surgery. For the proceedings, see the minutes of that section.

FRIDAY, JUNE 14—MORNING

The chairman, Dr. W. S. Rankin, Raleigh, N. C., called the meeting to order at 9:20 o'clock.

The following officers were elected: chairman, Dr. C. St. Clair Drake, Springfield, Ill.; vice chairman, Dr. J. W. Schereschewsky, Washington, D. C.; secretary, Dr. Donald B. Lowe, Akron, Ohio; delegate, Dr. W. S. Rankin, Raleigh, N. C.

The chairman then introduced Dr. Victor C. Vaughan, Colonel, M. C., N. A., as the presiding officer, owing to the military nature of the program.

The following papers were read as a symposium on "Military Hygiene and Preventive Medicine":

Dr. Rufus I. Cole, New York: "Prevention of Pneumonia."

Dr. Simon Flexner, New York: "Control of Meningitis."

Dr. Martha Wollstein, New York: "Mumps."

These three papers were discussed by Drs. Victor C. Vaughan, Ann Arbor, Mich.; Frederick F. Russell, Washington, D. C.; P. F. Armand-De Lille, Boulogne, France; William C. Rucker, Washington, D. C.; H. Gideon Wells, Chicago; H. B. Hemenway, Springfield, Ill.; Simon Flexner, New York; Martha Wollstein, New York, and Rufus I. Cole, New York.

Dr. Wilbur A. Sawyer, Berkeley, Calif., read a paper on "Venereal Disease Control in the Army." Discussed by Drs. Victor C. Vaughan, Ann Arbor, Mich.; P. S. Schenk, Norfolk, Va.; J. O. Cobb, Colonel, U. S. P. H. S., and C. St. Clair Drake, Springfield, Ill.

Dr. C. F. Gelston, engaged for a year or more in assembling and helping to take care of the civilian people who have been returned from Germany to France, made a few remarks.

SECTION ON GENITO-URINARY DISEASES

WEDNESDAY, JUNE 12—MORNING

The meeting was called to order by the chairman of the Executive Committee, Dr. Granville MacGowan, Los Angeles, at about 9 o'clock, who stated that because of the absence of the chairman of the section in France, and the death of the vice chairman, the conduct of the meeting developed on the Executive Committee, through its chairman, and that there would be no address by the chairman.

Dr. E. Otis Smith, Cincinnati, read a paper on "Anatomic and Pathologic Study of the Posterior Urethra."

Dr. Ernest M. Watson, Buffalo, read a paper on "The Human Vesicles at Birth, with Observations in Their Fetal Development."

Dr. Granville MacGowan, Los Angeles, read a paper on "Why Trained Urologists Should Be Employed to Treat Disease Conditions of the Posterior Urethra and the Bladder Neck."

These three papers were discussed by Drs. Charles M. Harpster, Toledo, Ohio; William T. Belfield, Chicago; Bransford Lewis, St. Louis; V. G. Vecki, San Francisco; John R. Caulk St. Louis; A. L. Wolbarst, New York; A. E. Goldstein, Baltimore, and V. D. Lespinasse, Chicago.

Drs. Loyd Thompson, Hot Springs, Ark., and Jacob Bolasny, Detroit, presented a paper on "Venereal Disease in the Thirty-Ninth Division." Discussed by Drs. F. M. McCallum Kansas City; V. G. Vecki, San Francisco; A. L. Wolbarst, New York; John R. Caulk, St. Louis; A. E. Goldstein, Baltimore; W. J. Wallace, Oklahoma City; A. E. Mowry, Chicago; W. G. A. Schulte, Salt Lake City; William C. Quinby, Boston; E. H. Martin, Hot Springs, Ark.; Charles M. Harpster, Toledo, Ohio; Lawrence T. Price, Richmond, Va., and Granville MacGowan, Los Angeles.

WEDNESDAY, JUNE 12—AFTERNOON

Dr. Arthur L. Chute, Boston, read a paper on "Some Cases of Retention of Urine Associated with Defects of the Sacrum, Probably Spina Bifida Occulta." Discussed by Drs. J. A. Gardner, Buffalo; William F. Braasch, Rochester, Minn.; Leland Boogher; St. Louis; H. L. Kretschmer, Chicago; J. Dellinger Barney, Boston, and J. P. O'Neil, Chicago.

The chairman recounted briefly the circumstances attending the death of Dr. Martin Krotoszyner of San Francisco, and appointed as a special committee to prepare suitable obituary resolutions Drs. A. L. Wolbarst, New York; Rufus L. Rigdon, San Francisco, and J. L. Boogher, St. Louis.

The chairman announced that Dr. Arthur L. Chute, Boston, had been selected by the Executive Committee to fill the place of Dr. Hugh Cabot, Boston, on the Executive Committee during this meeting.

Dr. Henry G. Bugbee, New York, read a paper on "Renal Complications of Pregnancy from the Standpoint of the Urologist." Discussed by Drs. Herman L. Kretschmer, Chicago; John R. Caulk, St. Louis; V. D. Lespinasse, Chicago, and A. E. Goldstein, Baltimore.

A paper by Dr. Frank Hinman, San Francisco, was read on "Experimental Hydronephrosis: Repair Following Ureterocystoneostomy in White Rats with Complete Ureteral Obstruc-

tion." Discussed by Drs. J. Dellinger Barney, Boston; James A. Gardner, Buffalo; Henry G. Bugbee, New York, and V. D. Lespinasse, Chicago.

Dr. Anders Peterson, Rochester, Minn., read a paper on "Effect on the Kidney and Ureter Following Transplantation into the Bladder." Discussed by Drs. Granville MacGowan, Los Angeles; V. D. Lespinasse, Chicago; Arthur L. Chute, Boston; Charles M. McKenna, Chicago; Bernhard Erdman, Indianapolis, and F. C. Herrick, Cleveland.

Dr. Robert H. Herbst, Chicago, read a paper on "Acquired Stricture of the Lower End of the Ureter." Discussed by V. D. Lespinasse, Chicago; John R. Caulk, St. Louis; William M. Spitzer, Denver; Gustav Kolischer, Chicago; Bernhard Erdman, Indianapolis; J. Dellinger Barney, Boston; Arthur L. Chute, Boston, and William F. Braasch, Rochester, Minn.

Friday, June 14—Morning

Drs. V. G. Vecki, San Francisco; William C. Quinby, Boston, and C. M. Harpster, Toledo, Ohio, were appointed as a nominating committee.

The following officers were elected: chairman, William F. Braasch, Rochester, Minn.; vice chairman, R. L. Rigdon, San Francisco; secretary, E. O. Smith, Cincinnati; delegate, Granville MacGowan, Los Angeles; alternate, H. G. Hamer, Indianapolis.

The address of the chairman, Dr. Edward L. Keyes, Jr., was read.

Dr. Bransford Lewis, St. Louis, read a paper on "New Instruments in Operative Cystoscopy." Discussed by Drs. William F. Braasch, Rochester, Minn., and H. L. Kretschmer, Chicago.

Dr. Oswald S. Lowsley, New York, read a paper on "Surgery and Surgical Pathology of the Human Prostate Gland." Discussed by Drs. H. L. Kretschmer, Chicago; Arthur L. Chute, Boston; V. D. Lespinasse, Chicago; W. G. A. Schulte, Salt Lake City; Bransford Lewis, St. Louis; Gustav Kolischer, Chicago; B. L. Guyatt, Binbrooke, Ont.; Granville MacGowan, Los Angeles; L. E. Schmidt, Chicago, and A. E. Goldstein, Baltimore.

Dr. James A. Gardner, Buffalo, read a paper on "The Silent Prostate." Discussed by Drs. H. L. Kretschmer, Chicago; James B. Cross, Buffalo; J. Dellinger Barney, Boston; Bernhard Erdman, Indianapolis; W. G. Schulte, Salt Lake City; Oswald S. Lowsley, New York; William C. Quinby, Boston; Gustav Kolischer, Chicago; L. E. Schmidt, Chicago; V. D. Lespinasse, Chicago, and C. M. Harpster, Toledo, Ohio.

The committee named to draft resolutions on the death of the vice chairman, Dr. Martin Krotoszyner, San Francisco, reported the following:

Whereas, Dr. Martin Krotoszyner was for many years one of the leading urologists of the Pacific Coast; and

Whereas, He stood high in the affections and respect of his confrères, both at home and throughout the nation, and was recognized as a man of honor, a friend who was loyal, a physician of scientific mind and a co-member of our society who was always enthusiastically ready to further its interests, and

Whereas, On the afternoon of April 20, 1918, while engaged in his office consultations he was wantonly shot to death by a man of disordered mind whose ills he had attempted to heal; and

Whereas, In his death his family lost a loving husband and father, his city was deprived of a public spirited citizen, and the medical profession lost one of its most sincere and untiring members; and

Whereas, Dr. Krotoszyner had been actively interested in the Section on Genito-Urinary Diseases of the American Medical Association since the organization of that Section, and at its meeting one year ago was elected to the office of vice chairman; therefore, be it

Resolved, That we, Fellows of the A. M. A., registered in this section hereby express our feelings of sincere sorrow at his untimely taking away and our sense of loss in his absence from our meeting, and his cooperation in our councils; and

Resolved, That we extend to his wife and family our deepest sympathy in their bereavement, and we assure them that his memory will be cherished by this section as one who stood for the highest and best ideals in medicine; and be it further

Resolved, That these resolutions be spread on the minutes of the section and become a part of its records, and that a copy be forwarded to his family.

The foregoing resolutions were adopted by rising and unanimous vote.

Friday, June 14—Afternoon

Dr. William C. Quinby, Boston, read a paper on "Treatment of Genital Tuberculosis in the Male." Discussed by Drs. J. Dellinger Barney, Boston; J. P. O'Neil, Chicago; James A. Gardner, Buffalo, and Oswald Lowsley, New York.

Dr. J. Dellinger Barney, Boston, read a paper on "Colon Bacillus Infection of the Urinary Tract."

Dr. Louis E. Schmidt, Chicago, read a paper on "The Significance of Bacteriuria."

These two papers were discussed by Drs. H. L. Kretschmer, Chicago; Granville MacGowan, Los Angeles; Oswald S. Lowsley, New York; Bransford Lewis, St. Louis; C. M. McKenna, Chicago, and C. W. Bethune, Buffalo.

Dr. Louis E. Schmidt, Chicago, moved the adoption of the following: That the membership of this section unanimously request that its name be changed to that of the Section on Urology, its scope to be the same as heretofore.

The motion carried by unanimous vote. [Not transmitted to the House of Delegates.]

Dr. Albert E. Goldstein, Baltimore, read a paper on "The Diagnostic and Prognostic Value of Blood Urea in Urology." No discussion.

SECTION ON ORTHOPEDIC SURGERY

Wednesday, June 12—Morning

The section was called to order at 9:05 by the chairman, Dr. Albert H. Freiberg, Cincinnati. Dr. Freiberg made some announcements and appointed, as vice president pro tem., Dr. J. D. Griffith, Kansas City; and as members of the Executive Committee pro tem., Drs. Frank E. Peckham, Providence, R. I.; Arthur Steindler, Iowa City, Iowa, and A. R. Colvin, St. Paul.

Dr. Leo Mayer, New York, read a paper on "Tendon Operation Technic." Discussed by Drs. Arthur Steindler, Iowa City, Iowa; E. H. Smith, San Francisco; C. M. Jacobs, Chicago; M. A. Bernstein, Kenosha, Wis., and Leo Mayer, New York.

Dr. Walter G. Stern, Cleveland, read a paper by himself and Dr. M. E. Blahd, Cleveland, on "Cerebral Spastic Paraplegia." Discussed by Drs. George B. Packard, Denver; E. H. Smith, San Francisco; John Ridlon, Chicago, and Walter G. Stern, Cleveland.

Dr. Frank E. Peckham, Providence, R. I., read a paper on "A Further Report of the Operation for Stabilizing the Foot and Ankle in Poliomyelitis." Discussed by Drs. Walter G. Stern, Cleveland, and Frank E. Packham, Providence.

Dr. Melvin S. Henderson, Rochester, Minn., read a paper on "Loose Bodies in the Elbow Joint." Discussed by Drs. W. C. Campbell, Memphis, Tenn.; A. R. Colvin, St. Paul; A. H. Freiberg, Cincinnati; Arthur Steindler, Iowa City, Iowa; Leo Mayer, New York; C. A. Parker, Chicago; J. D. Griffith, Kansas City, Mo., and Melvin S. Henderson, Rochester, Minn.

Dr. Arthur Steindler, Iowa City, Iowa, read a paper on "Orthopedic Operations on the Hand." Discussed by Drs. John L. Porter, Chicago; J. P. Lord, Omaha; Melvin S. Henderson, Rochester, Minn.; C. M. Jacobs, Chicago, and Arthur Steindler, Iowa City, Iowa.

Dr. W. Barnett Owen, Louisville, Ky., read a paper on "Efficient Support for Sacro-Iliac Relaxation." Discussed by Drs. F. J. Gaenslen, Milwaukee; C. A. Parker, Chicago; J. P. Lord, Omaha; John L. Porter, Chicago; E. H. Smith, San Francisco, and W. Barnett Owen, Louisville, Ky.

Wednesday, June 12—Afternoon

A joint meeting was held with the Section on Preventive Medicine and Public Health.

The meeting was called to order at 2:10 by Dr. A. H. Freiberg, Cincinnati, chairman of the Section on Orthopedic Surgery. Dr. Freiberg read an announcement about draft board managers, and then surrendered the Chair to Dr. J. D. Griffith, Kansas City, Mo.

Dr. A. H. Freiberg, Cincinnati, read the chairman's address, entitled, "Military and Industrial Orthopedic Surgery."

Dr. Charles G. Farnum, Peoria, Ill., read a paper on "Modern Industrial Medicine and Surgery."

Dr. Clarence D. Selby, Toledo, Ohio, read a paper on "Conserving Industrial Man Power."

These two papers were discussed by Drs. J. W. Schereschewsky, Washington, D. C.; Charles G. Farnum, Peoria, Ill., and Clarence D. Selby, Toledo, Ohio.

Dr. Francis D. Patterson, Harrisburg, Pa., read a paper on "Reconstruction Work in Industrial and Military Life." Discussed by Drs. C. G. Farnum, Peoria, Ill.; O. P. Geier, Cincinnati; J. D. Griffith, Kansas City, Mo.; W. G. Stern, Cleveland; E. P. S. Miller, Chicago, and F. D. Patterson, Harrisburg, Pa.

Mr. Charles S. Andrus, Chicago, Ill., read a paper on "Responsibility of the Industrial Board and the Influence of the Medical Examiner." Discussed by Dr. Wilmer Krusen, Philadelphia, and Mr. C. S. Andrus, Chicago.

FRIDAY, JUNE 14—MORNING

The meeting was called to order at 9:05 by the chairman, Dr. A. H. Freiberg, Cincinnati.

The following officers were elected: chairman, Dr. Emil S. Geist, Minneapolis; vice chairman, Dr. Benjamin P. Farrell, New York; Executive Committee, Dr. Russell A. Hibbs, New York, chairman; Dr. A. H. Freiberg, Cincinnati, and Dr. E. W. Ryerson, Chicago; delegate, Dr. John Ridlon, Chicago. The secretary, Dr. H. B. Thomas, Chicago, retains his office for two more years.

A letter from Col. Sir Robert Jones of London was read, and a motion was carried directing the secretary to write to Colonel Jones expressing appreciation and regard.

The executive session adjourned at 9:15, and the scientific program was resumed.

Dr. Robert B. Cofield, Cincinnati, read a paper on "Disinfection of the Knee Joint." Discussed by Drs. C. A. Parker, Chicago; J. P. Lord, Omaha; A. H. Freiberg, Cincinnati, and Robert B. Cofield, Cincinnati.

Dr. Leo Mayer, New York, showed the slides belonging to his paper on "Tendon Operation Technic," which was read on Wednesday morning. Discussed by Drs. A. H. Freiberg, Cincinnati, and Leo Mayer, New York.

Dr. Russell A. Hibbs, New York, presented a paper on "Final Report of Operations for Pott's Disease." Discussed by Drs. C. M. Jacobs, Chicago; W. C. Campbell, Memphis, Tenn.; F. J. Gaenslen, Milwaukee; H. B. Thomas, Chicago; Benjamin P. Farrell, New York, and R. A. Hibbs, New York.

Dr. David Silver, Pittsburgh, read a paper on "Problem of the Artificial Arm." Discussed by Drs. John Ridlon, Chicago; J. P. Lord, Omaha; Arthur Steindler, Iowa City, Iowa; Leo Mayer, New York; S. C. Baldwin, Salt Lake City, and David Silver, Pittsburgh.

Dr. Charles R. McClure, Portland, Ore., read a paper on "Isolated Disease of the Scaphoid." Discussed by Drs. W. C. Campbell, Memphis; S. C. Baldwin, Salt Lake City, and Charles R. McClure, Portland, Ore.

Dr. Robert Emmett Farr, Minneapolis, read a paper on "Illustrations and Demonstration of Bone-Holding Forceps." No discussion.

The chairman appointed Drs. J. P. Lord, Omaha, and R. B. Cofield, Cincinnati, as members of the executive committee to act in the places of Drs. A. R. Colvin and Frank E. Peckham.

SECTION ON GASTRO-ENTEROLOGY AND PROCTOLOGY

WEDNESDAY, JUNE 12—MORNING

The meeting was called to order at 9 o'clock by the chairman, Dr. Anthony Bassler, New York.

Dr. Anthony Bassler, New York, read the chairman's address.

Dr. Charles D. Aaron, Detroit, read a paper on "A Simplified Method of Aspirating Gastric Contents in Hypersensitive Patients." Discussed by Drs. M. H. Mack, Chicago; J. M. Rector, Columbus, Ohio, and J. Russell Verbrycke, Jr., Washington, D. C.

Dr. William M. Beach, Pittsburgh, read a paper on "The Subnormal Colon." Discussed by Drs. D. H. Murray, Syracuse, N. Y.; E. L. Eggleston, Battle Creek, Mich.; William H. Stauffer, St. Louis, and Nathan Rosewater, Cleveland.

Dr. Dwight Henderson Murray, Syracuse, N. Y., read a paper on "A Résumé of Eight Years' Original Research Work in the Etiology and Treatment of Pruritus Ani." Discussed by Drs. J. M. Frick, Toledo, Ohio; James A. Duncan, Toledo, Ohio; Thomas Charles Martin, Washington, D. C., and Anthony Bassler, New York.

Dr. Sidney K. Simon, New Orleans, read a paper on "The Comparative Value of Crude Ipecac and Its Alkaloids in the Treatment of Amebiasis." Discussed by Drs. Frank Smithies, Chicago; Hugo A. Freund, Detroit, and Horace W. Soper, St. Louis.

The paper of Dr. Max Einhorn, New York, on "The Importance of Detailed Examination of Drafted Men with Regard to Their Ability to Be Soldiers," was read. No discussion.

Drs. Dwight Henderson Murray, Syracuse, N. Y., William H. Stauffer, St. Louis, and William Van Valzah Hayes, New York, were appointed by the chair as a nominating committee.

WEDNESDAY, JUNE 12—AFTERNOON

The meeting was called to order at 2 o'clock by the chairman.

The following officers were elected: chairman, Dr. William M. Beach, Pittsburgh; vice chairman, Dr. Frank Smithies, Chicago; secretary, Dr. Horace W. Soper, St. Louis; delegate, Dr. Willian Van Valzah Hayes, New York; alternate, Dr. T. Chittenden Hill, Boston; executive committee, Drs. Charles G. Stockton, Buffalo; Dwight H. Murray, Syracuse, N. Y., and Anthony Bassler, New York.

Dr. Frank Smithies, Chicago, read a paper on "Pericholecystitic Adhesions: Their Importance and Clinical Recognition." Discussed by Drs. Robert T. Morris, New York; G. A. Friedman, New York; Mary E. Dunning Rose, New York; William Van Valzah Hayes, New York, and Roland Hazen, Paris, Ill.

Dr. G. A. Friedman, New York, read a paper on "The Probable Endocrinic Origin of Peptic Ulcer." Discussed by Drs. Frank C. Mann, Rochester, N. Y.; V. A. LaPenta, Indianapolis; Betram W. Sippy, Chicago, and Martin E. Rehfuss, Philadelphia.

Dr. Martin E. Rehfuss, Philadelphia, read a paper on "The Possibilities of Fractional Gastric Analysis." Discussed by Drs. William Van Valzah Hayes, New York; Frank Smithies, Chicago, and A. F. R. Andresen, Brooklyn.

Dr. Thomas Charles Martin, Washington, D. C., read a paper on "An Operation for Internal Hemorrhoids under Local Anesthesia." Discussed by Drs. Marvin H. Smith, Jacksonville, Fla.; William M. Beach, Pittsburgh; J. Rawson Pennington, Chicago; Dwight H. Murray, Syracuse, N. Y.; William H. Stauffer, St. Louis, and Charles D. Aaron, Detroit.

FRIDAY, JUNE 14—MORNING

The meeting was called to order by the chairman.

Dr. Harry B. Eisberg, New York, read a paper on "Intestinal Obstruction: Continued Studies from Surgical Research Laboratory, New York University." Discussed by Drs. Dwight Henderson Murray, Syracuse, N. Y., and James J. Moorehead, Chicago.

Dr. J. Rawson Pennington, Chicago, read a paper on "The End-Results of Operations for Cancer of the Rectum, with Suggestions for Improving Them." Discussed by Drs. Dwight Henderson Murray, Syracuse, N. Y; William M. Beach, Pittsburgh; Charles J. Drueck, Chicago, and George E. Pfahler, Philadelphia.

Dr. George E. Pfahler, Philadelphia, read a paper on "The Importance of Complete Roentgen Study of the Gastro-Intestinal Tract and Gallbladder in All Obscure Abdominal Cases." Discussed by Drs. Bertram W. Sippy, Chicago; William Van Valzah Hayes, New York; Aloys Heinen, Chicago; J. M. Rector, Columbus, Ohio; John Guttman, New York, and Horace W. Soper, St. Louis.

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SATURDAY, JUNE 29, 1918

WAR TIME DIFFICULTIES IN PRACTICAL DIETETICS

The new adjustments of food conditions thus far experienced in American homes have been brought about by voluntary effort and economic necessities rather than by governmental procedure. There has been no attempt at compulsory rationing, such as has been attempted abroad. "The Food Administration," said Herbert C. Hoover in a recent address, "has not taken the attitude of the general in command giving orders. Our attitude to the American public has been consistent, that we should ask for service, that we should ask for self-sacrifice, that we should tell in a clear and direct way the why and wherefore of every request. . . . The Food Administration has been founded on voluntary effort. We have no desire to depart from this idea, but if we are to accomplish our purpose it must be accomplished by voluntary effort."

Even an honor system of voluntary rationing requires the application of intelligence in the readjustment of dietaries occasioned by the exclusion or reduction of certain items in the diet. The difficulties are not diminished by the fact, already demonstrated by a single year's experience, that the conditions of supply may change from month to month in such a way as to require new plans. We must almost adjust ourselves, like an army in the field, to the day's orders. If the more intelligent classes of our communities are finding that this novel necessity taxes their ingenuity, how much greater must be the perplexity among those groups less competent to meet new situations with skill and forethought. How can a solution be found?

These comments have received added force from the experience that our English allies have acquired in the conduct of the large number of hostels where, under governmental patronage, great numbers of munition workers are now fed. Catering according to custom is an impossibility in a war time canteen. The problem of satisfying the boarder and obeying the mandates of the food administration at the same time has tried the matrons set to the tasks. The crux of the situation has been clearly stated by Miss Chrystal[1] of the Welfare and Health Section, Ministry of Munitions: "The best use of substitutes and the most economical use of food generally are matters which require a great deal of skill, and which may be beyond the powers of ordinary English cooks."

Such perplexities are assuredly not negligible. Our military authorities have begun to realize the true value of a trained army cook; the civilian armies must also be provided for. Some of the difficulties encountered in the new kind of service that hostels represent are worth mentioning because they have both psychologic and physiologic import in nutrition. Variety affects efficiency both physically in relation to digestion and psychologically. Sameness is apt to characterize institutional food, and it is not surprising that hostel catering should have the same fault. Detailed observation has led inspectors to believe that one of the secrets of successful hostel management lies in preserving the tenants' interest in their meals. It is a common experience in hostels that the nerve strain of heavy munition work produces in women a disposition to be difficult about food, and where there is little discontent it is generally found that variety of food is studied. The great difficulty is that, although monotony is resented, the workers are conservative and suspect new dishes.

The munition worker is not unlike the patient that demands a diet list from his physician. Geographic and racial peculiarities and dietary customs offer almost insurmountable obstacles to many rational innovations. Thus one hostel inspector reports that "potato dishes are being tried with considerable success. Maize has been found to be unpopular and indigestible. Suet puddings and rolls are thought by the workers to be sustaining." Not only the proper selection and cooking of food, but also suitable service is indispensable to success. And the problem of waste looms up larger as the food stores become smaller.

In the face of such emergencies it behooves the medical profession to welcome and encourage in this country the growth of a movement that is destined to bring help and stimulus in meeting these problems of the art of living. Home economics has too long been looked on as a fad. Rule of thumb methods are no longer synonymous with household arts. Witness the speedy success with which substitutive cereals have been employed in cookery throughout the United States within the past few months. From the primary schools to the colleges for women our girls are being taught the dignity of home economics and the underlying sciences. Our profession is all too slow in realizing what these newer forms of theoretical and

1. Chrystal, E. M.: Food in Hostels, National Health Insurance, Medical Research Committee, Special Report Series, No. 13, Appendix III, 1918.

vocational education actually are destined to mean, not only to the hospital or institutional dietitian and to the trained nurse, but also to the nation at large. Let us dignify the art of dietetics.

THE ORIGIN OF COLOSTRUM

The milk that female mammals secrete during the first few days after parturition, at the beginning of their period of lactation, is quite different in composition from the fluid produced at a later stage. It is known under the name of colostrum, and the colostral characteristics persist for varying periods in different species. Colostrum is a more viscid fluid than the later milk. It is richer in proteins, particularly lactalbumin, and total solids; unlike ordinary milk, it may even coagulate on being heated. Colostrum contains many cells designated as milk corpuscles, which contain nuclear material, whereas later milk is essentially free from such products. Regarding the fat content, the statistics are somewhat uncertain; but it has been reported that the colostral fat has a higher melting point and more of the lipoids, cholesterol and lecithin, than has ordinary milk.

Many students of the value of milk as a nutrient have placed emphasis on the importance of colostrum in the nutrition of the young. They believe that, owing to its comparative richness in the different types of foodstuffs, colostrum helps to avert considerable declines in body weight and retardation of growth during the earliest period of infancy. For example, in Dr. Lane-Claypon's elaborate survey of milk and its hygienic relations, the following statement appears: There is no doubt that colostrum is of primary importance to the young animal, and there is no way of replacing it. An infant deprived of the colostrum of its mother must endeavor, not always with success, to make up later the disadvantage under which it has labored at the start.[1] When it is added further that colostrum is supposed by some to have a laxative effect, the foundation for the belief of the special value of this secretory product for the first few feedings of the newly born will better be understood.

Other investigators, on the other hand, have not accepted this purely teleological explanation for the occurrence of colostrum. They believe that this product is the temporary result of the imperfect activity of the mammary glands when they start their functioning. The peculiar composition of the fluid, with its comparative richness in cellular constituents, is regarded as a natural result of the washing out of ducts hitherto inactive. Not until the pent up cell débris is discharged does a standardized type of secretion ensue, on this hypothesis. A recent decidedly unique observation, made by Hill[2] at the Maryland Agricultural Experiment Station, may help to throw light on the real significance and origin of colostrum. A 4 months' old virgin doe kid spontaneously commenced to secrete milk having all characteristics, properties and chemical composition of the milk secreted by its mother and other goats under observation. At no time, from the earliest secretion of milk, was there any colostrum secreted. This would indicate that the secretion of colostrum is associated with and possibly is produced by the cessation of pregnancy, and may not occur in lactation not associated with pregnancy.

1. Lane-Claypon, Janet E.: Milk and Its Hygienic Relations, London, 1916.
2. Hill, R. L.: The Analysis of Milk Secreted by a Suckling Doe Kid, Jour. Biol. Chem., 1918, 33, 391.

A BRITISH VIEW OF THE AMERICAN MEDICAL ASSOCIATION'S WAR ACTIVITIES

The *British Medical Journal* (June 1) comments on the editorials which appeared in THE JOURNAL, April 20 and 27, relative to the call of Surgeon-General Gorgas for five thousand more medical officers. Our confrère observes that the American Medical Association offered its services to the government at the time the United States entered the war just as did the British Medical Association at the beginning of the conflict, and intimates that we are going through their experience when we call only for a sufficient number of volunteers to meet immediate needs. As to this, of course the Surgeon-General is not endeavoring to supply the immediate needs, because these have been supplied; what the Surgeon-General desires is to prepare for future needs. Incidentally we might add that this need may not be far distant, judging from the outlook for rapid enlargement of our National Army.

Referring to the call of our Surgeon-General, the *British Medical Journal* says: "The American Medical Association, like the British Medical Association, has a War Commitee which is taking up this call with energy and enthusiasm. The Surgeon-General desires that the five thousand shall be secured without serious hardship to any community, manufacturing concern or other civil activity, and consequently the American Medical Association has begun to investigate the conditions in all parts of the country so as to produce a survey which will 'provide a basis for accurate, intelligent, cooperative effort.'" It goes on to say that our War Committee, as did theirs, deliberated on the advisability of calling for a voluntary draft, which would mean that every physician in active practice would volunteer as a member of the Medical Reserve Corps and be subject to call. "The American Medical Association has deemed this extreme measure [that is, voluntary draft] unnecessary for the present at least. The organization of such a scheme would have afforded excellent training for the work the Association will have to face if ever it becomes necessary in America to pass a military service act in

any way comparable to that which has been found necessary in Great Britain." However, attention is called to the relatively large number of medical practitioners in America as compared with the number in Great Britain.

Quoting our statement that "the time has come for every medical man under 55 years of age who is physically qualified to consider seriously for himself the question of his duty to his government," the *British Medical Journal* suggests that "no individual practitioner can possibly judge for himself the medical needs of the community in which he practices or the hardship which he himself will suffer." This fact is being recognized in the work being done by the state and county organizations. It is appreciated that even the county society, except where the county includes large centers of population and consequently a large number of physicians, is seldom qualified to pass judicially on the question as to whether such and such a man could be spared or should offer his services. The plan now being tested out in some of the Councilor Districts of Nebraska is more likely to result in judicious conservative selection, with personal bias eliminated. There, as mentioned elsewhere in this issue, it is proposed that a committee composed of a representative from each county society in the Councilor District, with the councilor of the district acting as chairman, shall indicate those who should apply for commission and in what order, so that the quota assigned to that district will be available.

WAR GASES AND ANTIVIVISECTIONISTS

According to investigations in progress on animals at the Rockefeller Institute for Medical Research,[1] some degree of analgesia may be produced by at least three widely different war gases—chlorin, phosgen and dimethylsulphate[2]—and may perhaps be a property of most gases usable for military purposes. Auer, who has conducted the experiments with dimethylsulphate, has reported that in animals gassed with fumes of this compound a strong generalized analgesia is observed within a few hours after exposure to the fumes, which reaches a high degree within twenty-four hours. If the animal survives, the analgesia may still be well marked six months afterward. Furthermore, we are assured that in such animals severe operations may be performed without any anesthetic, the operation eliciting no indications or only slight indications of pain. If these experimental observations find their counterpart in the experience of the battlefield, the analgesic property may be utilizable in gassed soldiers who are also wounded and require surgical intervention.

A further possible practical outcome of the animal experiments with dimethylsulphate fumes relates to the necropsy findings of localized pulmonary edema as a result of gassing.[3] The edema rarely involves the whole lung, only a certain lobe or portions of a lobe showing a striking degree of pulmonary edema. It is by no means infrequent to find one lobe fairly saturated, while the rest of the entire lung tissue is practically free from fluid.

According to Auer, this condition is due apparently to the combination of a partial or complete stenosis of a bronchus or bronchiole with inspiratory dyspnea. A marked inflammation of the respiratory passages with pseudodiphtheritic membrane formation may occur locally. Therefore during each inspiration, which is slow, labored and prolonged in the gassed animal, the capillaries of the alveolar walls are subjected to an aspirating action which facilitates or initiates the passage of a transudate into the alveolar spaces. The production of this transudate is probably also aided by a local damage of the alveolar epithelium which the war gas produces. So far as such conditions may be found in gassed soldiers, it is suggested that all inspiratory dyspnea should be ameliorated as much as possible, by tracheotomy and artificial respiration if necessary, aiming by this means to ward off pulmonary edema.

And in the meantime, while patient investigators are trying their best by animal experimentation to kindle a spark of hope for the unfortunate victims of a fiendish mode of warfare, the complacent stay-at-home "antivivisectionists" and their mouthpiece—*Life*—are doing their worst to extinguish it. Shall humanity tolerate such traitors to its cause? Speaking of this "menace of unreason as applied to problems concerning hygienic and moral measures that affect the rights of the individual and society," Joseph Jastrow, professor of psychology in the University of Wisconsin, says in a recent work on "The Psychology of Conviction":

> Upon the basis of a similarly inspired opposition—and one quite as unintelligent—we have the anti-vaccinationists; and reaching to higher circles where prejudices, like other beliefs, acquire a more moralized statement, the antivivisectionists. It is gratifying to record that American conditions up to the present have not been as favorably disposed toward this propaganda of unreason as to others; yet it is possible to cite the well-known fact that a popular periodical, which ministers to the relaxations of life and stands for that sanity of view which a sense of humor so notably confers, which circulates among the more cultivated classes of society, incessantly preaches an ignorant and false crusade, brutally misrepresents the noble army of experts who are carrying the triumphs of science into the field of deepest concern to human interests, criticizes without authority and ignores the open records of achievement; while in the main stultifying its own position, it unquestionably fosters the cause of prejudice.

1. Auer, J.: Generalized Analgesia in Cats After Exposure to a War Gas $(CH_3)_2SO_4$. Proc. Soc. Exper. Biol. and Med., 918, **15**, 104.
2. Neiding: Russk. Vrach, 1917, **16**, 397.
3. Auer, J.: Localized Pulmonary Edema in Cats After the Inhalation of a War Gas $(CH_3)_2SO_4$. Proc. Soc. Exper. Biol. and Med., 1918, **15**, 106.

Current Comment

INTERN TRAINING AND STANDARDIZING OF HOSPITALS

The medical graduate who has spent a year or more as an intern in a good hospital is acknowledged to be so much better prepared for his professional career than the man without it, that this internship should be required of all medical students. The making of such a requirement rests with either the medical schools or the state licensing boards. Already eight medical schools have made the intern year mandatory for the degree, and seven state licensing boards have made it an essential qualification for a license. As the intern service becomes an essential part of the training of medical students—a requirement rather than an optional, extramural course—its character and content must be subject to regulation. Each school or state board which adopts this requirement must decide what are the essential qualifications whereby a hospital can provide a satisfactory intern training, and must prepare a list of the hospitals which, in its judgment, possess these qualifications and whose internships it will recognize. The standardization of intern training and the classification of hospitals on the basis of their facilities for intern instruction have been a part of the program of the Council on Medical Education of the American Medical Association since it first took up the work of improving the standards of medical education. The Council has already made two surveys of hospitals and published two editions of a list of those considered qualified to provide acceptable internships. It is now making a third survey and has just sent out a questionnaire to all of the hospitals of the country reporting interns. In cooperation with the Council, the state medical associations are appointing hospital committees to act in an advisory capacity as the survey progresses. Besides the collecting of this information concerning the hospitals which provide internships, and as conditions may require it, it is proposed to make inspections of certain hospitals. In this standardization of hospitals, special emphasis will be laid on the qualifications of the hospital staff, the adequacy of its equipment for modern, scientific diagnostic and therapeutic procedure, the work required of its interns, and the supervision given to that work. It is on these points chiefly that the value of the intern's training depends. The intern year must become of equal rank educationally with the previous four years of the student's medical course. The staffs of hospitals should look on their relation to the intern as that of teacher to student. Some hospitals and their staffs have long felt this responsibility and have given their interns training of high quality. In the majority, however, there will need to be something like a revolution in the hospital's conception of its duty to the intern. The hospital must recognize that while primarily it secures the aid of trained interns so as to provide adequate and proper care for the sick, and thus is better able to fulfil its duty and responsibility to the community, actually the hospital secures the services of these interns without expense because it is presumed to give the student a quid pro quo in the form of advanced clinical instruction and experience.

THE RESPONSE OF THE MEDICAL PROFESSION

We understand that during the four weeks since the publication of the "Honor Roll" in THE JOURNAL (June 1), practically 2,775 physicians have made application for commission in the Medical Reserve Corps and a little less than 200 for commission in the U. S. Naval Reserve Force. Of course, a certain percentage of these will be unable to qualify. However, it shows how well the medical profession is appreciating its responsibility. The question with the large majority of physcians is, Where can I best render service? Apparently many physicians have found the correct answer.

THE HONOR ROLL

May we again call the attention of those who desire to keep the "Honor Roll" (THE JOURNAL, June 1) complete and up to date to the fact that this may be done by adding to it the names of those accepting commissions which now appear in THE JOURNAL each week. In the present issue the names of 199 physicians are recorded as having accepted commissions in the Medical Reserve Corps of the Army and 180 as having accepted commissions in the U. S. Naval Reserve Force.

ONE FORM OF VOLUNTARY SELECTIVE CONSCRIPTION OF PHYSICIANS

The problem of supplying the required number of officers for the Medical Reserve Corps, without working "serious hardships on any community, manufacturing concern, or any other civil activity," is being solved, not by any hard and fast or harsh plan, and in applying it all over the country, but by simply keeping the principle in mind and applying it where and in the manner best suited to the conditions that exist in the community. A plan workable in one state may be impracticable in another. What may be an ideal scheme in Kansas or Nebraska might be impossible in New York or New Jersey. Among those being put to a practical test is that proposed by Johnson County, Nebraska. The members of this society have agreed that those under fifty-five years of age will apply for commission in the Army or Navy and will agree to accept the commission if granted. The action of this individual society, however, was taken with the understanding that it should be obligatory only in the event of the remaining counties of the Councilor District adopting it. This, as we understand, has been done by all the counties in the District. The plan outlined calls for a committee composed of one representative from each of the county societies of the District, with the Councilor of the District acting as chairman. This committee, therefore, represents not a small community, but a definite and

sufficiently wide territory to eliminate personal prejudice or personal influence; at the same time it has a knowledge of the actual conditions existing in every part of its territory. The plan is really carrying out the principles underlying the selective service regulations. It is an ideal voluntary conscription of the medical profession by itself, one that recognizes the needs of the community and the social condition of the individual practitioner.

Medical Mobilization and the War

Personnel Changes in Expeditionary Forces

Lieut.-Col. George P. Peed, M. C., U. S. Army, who has been in command of American Red Cross Military Hospital No. 1, Neuilly, France, and who later was made medical director of all American hospitals in Paris, has been assigned to new duties involving the organization of other American military hospitals. He has been replaced as military director by Lieut.-Col. Ernest G. Bingham, M. C., U. S. Army, who will correlate the work of all the military hospitals in Paris. Colonel Bingham has been succeeded as commanding officer of the hospital in Neuilly by Major James P. Hutchinson, M. R. C., U. S. Army, medical and surgical director of the institution.

Additions and Improvements to Hospital Buildings at Army Camps

Hospitals, convalescent barracks, infirmaries and nurses' quarters added to the hospital establishment of the Army in this country during the past six months, and in the course of construction by the Construction Division of the Army, have been estimated to cost $25,173,417.55. The following construction has been completed: A 500-bed addition to both of the hospitals at Camp Gordon and Camp Dodge, including officers' and nurses' quarters, at a cost of $550,000; additional two-story ward convalescent barracks at Army and National Guard base hospitals, with a capacity of from 300 to 900 beds, with umbrella sheds connecting them, at a cost of $9,179,000; two regimental infirmaries at each National Army cantonment and one regimental infirmary at each National Guard camp and remount depot, at a cost of about $344,000; dental infirmary operating building at National Guard camps and National Army cantonments, at an estimated cost of $912,000; a dental infirmary and an eye, ear, nose, and throat clinic at each National Guard camp at a cost of $139,200; an additional 1,500-bed hospital at Camp Merritt, at a cost of $1,115,000; a venereal tent hospital and additional hospital buildings at Camp Stuart, at a cost of $220,000; a 500-bed hospital at the engineers' training camp at Belvoir, at a cost of $1,125,000. It has been necessary also to install steam-cooking equipment in the general kitchens of hospitals on account of increased bed accommodations in National Army cantonments and National Guard camps; there have also been constructed nurses' quarters and additions to officers' quarters at a cost approximating $1,000,000, together with wards and isolation wards for the care of female nurses. These wards are also being established at Camps Merritt, Stuart, Humphreys, Johnston, and General Hospitals No. 2 at Fort McHenry (Md.), No. 6 at Fort McPherson, No. 8 at Otisville (N. Y.), and No. 10 at Fox Hills (N.Y.), at an estimated cost of $181,350. Sanitary accommodations have also been installed in the wards at the hospitals at National Army cantonments. Automatic fire-alarm systems have been installed in the hospitals of the National Army and National Guard camps, and at Camps Merritt, Stuart, Funston, Walter Reed General Hospital, and General Hospital No. 1 at New York, at an estimated cost of $1,200,000. Screening is being installed in all hospitals, and steam disinfectors at the National Army and National Guard camps, as w ell as at Camps Johnston, Stuart, Merritt, and at General Hospital No. 3, Colonia, N. J., at a cost of $69,721.

The following construction is in progress at the United States Army general hospitals: Additional hospital buildings in tile at the Walter Reed General Hospital, Washington, D. C., at a cost of $733,400; a 1,000-bed tuberculosis hospital at Denver, at a cost of $1,720,000; a 1,000-bed hospital for the same purpose at Azalea, N. C., at an approximate cost of $1,325,000; a 120-bed hospital at Norfolk, Va., at an approximate cost of $205,900; a 1,500-bed hospital at United States General Hospital No. 3, Colonia, N. J., at an estimated cost of $1,632,000; additional two-story nurses' quarters, accommodating 150 nurses, at United States General Hospital No. 6, Fort McPherson, Ga., at an approximate cost of $88,700; a hospital for the care of blind soldiers at Rolan Park, Md., to be known as the United States General Hospital No. 7, at an estimated cost of $140,446; a tuberculosis hospital with a capacity for 650 patients at General Hospital No. 8, Otisville, N. Y., at an estimated cost of $957,000; a hospital which will care for 1,762 patients at Fox Hills, N. Y., at a cost of $2,075,000; a two-story convalescent hospital at Fort Oglethorpe, Ga., at General Hospital No. 14, accommodating about 1,000 patients, at an estimated cost of $202,200. The Lakewood Hotel and "Florence in the Pines," at Lakewood, N. J., have been leased for hospital purposes at an annual rental of $58,500.

Changes in Personnel of British Army Medical Service in France

The Secretary of the War Office announces the retirement of Lieut.-Gen. Sir Arthur T. Sloggett as Director General, due to the fact that he has completed the period of his appointment and passed the age limit for service. Sir Arthur Sloggett is a Fellow of King's College, London, and began his army career in 1881; in 1884 he served on the Indian frontier; in 1896 he was senior medical officer of the British troops with the Dongola Expeditionary Force. He served in the Sudan in 1897-1898 in which campaign he was shot through the chest in the cardiac region; on his recovery he rendered distinguished service in South Africa. He then became P. M. O. of Home and London Districts, and of the Sixth Division in India, becoming Director-General of Medical Services in India in 1911, and Director-General A. M. S. at the War Office on June 1, 1914. He has been in France as Director-General Medical Services of the British armies in that country since October, 1914. His conspicuous success has been due to a great extent to his use of scientific methods and to his sympathy with the views of the civilian physicians who have served under him.

Sir Arthur Sloggett is to be succeeded by Major-General C. H. Burtchaell. Major-General Burtchaell graduated from the University of Dublin in 1889, entering the army in 1891. He served in the North-Western Frontier campaign in India in 1897-1898, being present at all the principal battles, and throughout the South African war, and in 1902 was appointed principal medical officer to the South African Constabulary; in 1905 he rejoined the army. In 1907 he organized the experimental scheme of sanitary training for fighting troops later adopted for the army. In 1908 he became director of the medical service work of the first medical tour held in the British Army, in 1910 becoming Assistant Director-General, Army Medical Services, War Office, having served as Assistant Director-General Medical Services in France since October, 1914. He was promoted to colonel in March, 1915, and to temporary Surgeon-General in October, 1917. He has distinguished himself in the present war, being mentioned seven times in dispatches and being awarded the C. B., the C. M. G., and the Legion of Honour. He is especially esteemed by the Dominion forces, having been associated with them for three years in the South African campaign.

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L. O. STONE, Kittrell

A. W. JAMES, Lawinburg
F. O. BELL, Linden
R. F. SLEDGE, Winston Salem

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A. P. MAGNESS, Akron
L. LEAVENWORTH, Canton
F. M. SAYRE, Canton
S. W. McEWAN, Cincinnati
R. W. FINLEY, Dayton

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J. J. SHARKEY, Philadelphia
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T. W. HUTSON, Aiken
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J. H. PRESCOTT, Edgefield
V. E. HOLCOMBE, Enoree
O. T. FINKLEA, Hyman

TENNESSEE

W. M. LOTT, Nashville
I. SIMONS, Nashville

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O. R. LASATER, Austin
J. F. ANDERSON, Fort Worth
W. L. FLECK, San Juan

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L. A. McALPINE, Portsmouth
E. T. TRICE, Richmond
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W. C. GIBSON, Suffolk

WASHINGTON

M. G. STURGIS, Seattle

WEST VIRGINIA

J. A. SANDERS, Oceana

WISCONSIN

G. F. MOORE, Madison
W. E. BRADBURRY, Millsville
G. M. MALKIN, Milwaukee
E. E. DOCKERY, Ripon

CORRECTION

Under "Orders to Officers of Medical Reserve Corps" in the issue of June 8 appeared the following order: To Camp Kearny, Linda Vista, Calif., base hospital, Capt. JAMES W. HOUSTIS, Los Angeles. This should have been, Capt. JAMES W. HEUSTIS.

PROMOTIONS

To colonel, M. C., N. A., Majors J. M. T. FINNEY and WILLIAM S. THAYER; to lieutenant-colonel, Majors THOMAS R. BOGGS, JAMES T. CASE, GEORGE W. GOLDTHWAITE, JAMES F. McKEEVER, CHARLES H. PECK, THOMAS A. SALMON, HUGH H. YOUNG, N. ALLISON and E. L. KEYES.

ORDERS TO OFFICERS OF THE MEDICAL CORPS AND OF THE MEDICAL CORPS OF THE NATIONAL ARMY

To Army Medical School for instruction, and on completion to Boston, Mass., Harvard Graduate School of Medicine, for instruction, and on completion *to his proper station*, from Camp Hancock, Capt. EDMOND J. WILLE. For instruction from Camp Sevier, Lieut. HARLIN G. TUCKER; from duty as officer in the Medical Reserve Corps, Lieuts. EDWARD A. LANE, RALPH M. DEGAAFF.

To Asheville, S. C., for inspection, and on completion *to his proper station*, from Biltmore, Lieut.-Col. WILLIAM H. SMITH.

To Camp A. A. Humphreys, Accotink, Va., as assistant to camp surgeon, from Camp Lee, Lieut. HENRY R. WESTON.

To Camp Cody, Deming, N. M., as assistant to camp surgeon, from Fort Slocum, Major ROBERT E. PARRISH.

To Camp Custer, Battle Creek, Mich., *Fort Oglethorpe* and *Camp Pike*, Little Rock, Ark., base hospitals, and on completion *to his proper station*, from Camp Dodge, Lieut.-Col. FRANK C. TODD.

To Camp Grant, Rockford, Ill., as assistant to camp surgeon, from Fort Clark, Major GEORGE B. LAKE.

To Camp MacArthur, Waco, Texas, as camp surgeon, from Southern Department, Major JOHN T. AYDELOTTE.

To Camp Merritt, Hoboken, and *Camp Raritan*, Metuchen, N. J., for inspection, and on completion *to his proper station*, Lieut.-Col. FLOYD KRAMER.

To Camp Pike, Little Rock, Ark., as camp surgeon, from Charleston, Major GARFIELD L. McKINNEY.

To Cape May, N. J., base hospital, from Camp Devens, Lieut. ARTHUR H. NYLEN.

To Charleston, S. C., Hot Springs, N. C., Knoxville, and *Nashville, Tenn., Huntsville, Ala., Cleveland, Ohio*, and *Pittsburgh, Pa.*, for duty, and on completion *to his proper station*, Lieut.-Col. JOHN A. HORNSBY. *To Charleston, S. C.*, for duty, from Camp Greene, Major ERNEST A. GATES.

To Fort Leavenworth, Kan., Department Laboratory, for duty, from Camp Doniphan, Lieut. FREDERIC H. THORNE.

To Hoboken, N. J., for duty, from Camp Custer, Lieut.-Col. NEAL R. WOOD.

To Mineola, L. I., N. Y., Hazelhurst Field, for duty, and on completion *to his proper station*, Col. WILLIAM O. OWEN.

To Newport News, Va., for consultation, and on completion *to his proper station*, Col. PEARCE BAILEY.

To New York City for duty, and on completion *to his proper station*, Col. WINFORD R. SMITH, Lieut.-Col. EDWARD B. VEDDER.

To Philadelphia, Pa., University of Pennsylvania, *New York City*, Bellevue Hospital, and Rockefeller Institute, for inspection, and on completion *to his proper station*, Lieut.-Col. RAYMOND P. SULLIVAN.

To Plattsburg Barracks, N. Y., for duty, from Fort Porter, Lieut.-Col. THOMAS D. WOODSON.

To Washington, D. C., for consultation, and on completion *to his proper station*, from Camp Shelby, Col. WILLIAM F. LEWIS. For duty in the Surgeon General's Office, from Walter Reed General Hospital, Major RAYMOND C. BULL.

The following order has been revoked: *To Hoboken, N. J.*, for temporary duty, from Camp Cody, Lieut.-Col. JOHN B. ANDERSON.

ORDERS TO OFFICERS OF THE MEDICAL RESERVE CORPS

Alabama

To Camp Jackson, Columbia, S. C., for duty, from Camp Gordon, Major CABOT LULL, Jr., Birmingham. With the board examining the troops for cardiovascular diseases, from Camp A. A. Humphreys, Lieut. HENRY C. HARRIS, Birmingham.

To Camp Joseph E. Johnston, Jacksonville, Fla., for duty, Lieut. EDWARD L. GIBSON, Enterprise.

To Camp Lee, Petersburg, Va., for duty, from Camp Wheeler, Lieut. FRANCIS M. INGE, Mobile.

To Fort Sam Houston, Texas, for duty, from Camp MacArthur, Lieut. THOMAS C. SAVAGE, Demopolis.

To Lincoln, University of Nebraska, for duty, from Fort Riley, Lieut. RUSSELL CALLEN, Birmingham.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion *to Williamsbridge, N. Y.*, for temporary duty, and on completion *to Hoboken, N. J.*, for duty, from Fort Riley, Major WESTLEY E. DRENNEN, Birmingham.

Arkansas

To Camp Dix, Wrightstown, N. J., for duty, from Camp Devens, Lieut. MAC McLENDON, Marianna.

To Camp Grant, Rockford, Ill., for duty, from Camp Pike, Capt. SCOTT C. RUNNELS, Little Rock.

To Camp Joseph E. Johnston, Jacksonville, Fla., for duty, from Fort Oglethorpe, Lieut. NEWMAN B. BURCH, Colt.

To Camp Pike, Little Rock, Ark., for duty, from Fort Riley, Lieut. CHARLES G. MINKLE, Batesville.

To Camp Travis, Fort Sam Houston, Texas, for duty, from Fort Oglethorpe, Lieut. MAURICE F. LAUTMAN, Hot Springs.

To Camp Taylor, Louisville, Ky., for duty, from Camp Pike, Lieut. FRANK L. CASTLEBERRY, Pentagold.

To Cape May, N. J., base hospital, from Camp Wheeler, Lieut. WALLACE D. ROSE, Little Rock.

To Hoboken, N. J., for duty, from Army Medical School, Lieut. JOHN S. WILSON, Plantersville; from Fort Oglethorpe, Lieut. ERNEST DARNALL, Widener.

California

To Camp Fremont, Palo Alto, Calif., base hospital, from San Francisco, Capt. WILLIAM L. ADAMS, Fresno.

To Camp Greene, Charlotte, N. C., base hospital, from Camp Kearny, Capt. CHARLES A. WAYLAND, San Jose.

To Camp Kearny, Linda Vista, Calif., base hospital, Capt. HARVEY L. THORPE, Los Angeles.

To Camp Lewis, American Lake, Wash., for duty, Capt. DONALD W. MACKENZIE, Yermo; Lieut. ALSON A. SHUFELT, San Francisco. With the board examining the troops for cardiovascular diseases, Lieut. DONALD CASS, San Francisco.

To Camp Meade, Annapolis Junction, Md., for duty, from Camp Kearny, Capt. LIONEL D. PRINCE, San Francisco.

To Camp Pike, Little Rock, Ark., base hospital, Capt. HENRY H. LISSNER, Los Angeles.

To Camp Shelby, Hattiesburg, Miss., as orthopedic surgeon, from Chicago, Lieut. OSCAR P. STOWE, Mill Valley.

To Fort Oglethorpe for instruction, Lieuts. JOHN R. SHEA, Los Angeles; EDMUND McCOY, San Francisco; from Fort Riley, Capt. BERTRAM C. DAVIES, Los Angeles.

To Lakewood, N. J., for duty, from Camp Dodge, Capt. BERTNARD SMITH, Los Angeles.

To report by wire to the commanding general, western department, for assignment to duty, Lieut. WALTER R. SCROGGS, Berkeley.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion *to Camp Custer*, Battle Creek, Mich., Capt. LAWRENCE H. HOFFMAN, San Francisco.

To San Francisco, Calif., for instruction, and on completion *to Camp Kearny*, Linda Vista, Calif., base hospital, Lieut. JAMES A. GUILFOIL, San Luis Obispo. On completion *to their proper stations*, from Camp Fremont, Lieut. CHANNING HALL, Alameda; from Camp Kearny, Capt. JOHN MALSLEY, Santa Monica. *To Letterman General Hospital*, for temporary duty, Lieuts. EDWARD R. COX, Los Angeles; CHARLES A. CRAIG, San Francisco.

To Talmadge, Calif., Mendocino State Hospital, for intensive training, Lieut. HERVYN HIRSCHFIELD, San Francisco.

The following order has been revoked: *To report by wire to the commanding general*, western department, for assignment to duty, Lieut. FRED O. BUTLER, Eldridge.

Colorado

To Army Medical School for instruction, from Camp Cody, Lieut. WILLIAM D. REMINGTON, Denver.

To Jackson, Barracks, La., for duty, Capt. ALBERT L. STUBBS, La Junta.

To report to the commanding general, southern department, for duty, from Fort Sam Houston, Capt. FRED F. STOCKING, Floresta.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion *to his proper station*, from Jefferson Barracks, Lieut. ARCHIBALD J. CHISHOLM, Antonio.

To San Francisco, Calif., for duty, from Fort Riley, Lieut. ARTHUR G. TAYLOR, Grand Junction.

Connecticut

To Camp Devens, Ayer, Mass., base hospital, Lieut. HENRY C. DIXON, Bridgeport. For duty, from Army Medical School, Lieut. HAROLD THOMAS, Hartford; from Fort Oglethorpe, Lieut. BERNARD F. GILCHRIEST, New Haven.

To Camp Dix, Wrightstown, N. J., for temporary duty, from Army Medical School, Lieut. HERMAN H. HURWITZ, Hartford.

To Camp Jackson, Columbia, S. C., for duty, from Fort Sam Houston, Capt. JAMES C. WILSON, Hartford. As a member of the tuberculosis examining board, from New Haven, Lieut. MARCUS C. BECK, Bridgeport.

To Camp Joseph E. Johnston, Jacksonville, Fla., for duty, from Fort Oglethorpe, Lieut. SIDNEY C. DALRYMPLE, Waterbury.

To Minneola, L. I., N. Y., Hazelhurst Field, Signal Corps Aviation School, for duty, Capt. ARTHUR E. BRIDES, New Haven.

To New Orleans, La., Charity Hospital, for instruction, and on completion *to his proper station*, from Camp Gordon, Major WILLIAM F. VERDI, New Haven.

To Rochester Minn., Mayo Clinic, for instruction, and on completion *to Camp Custer*, Battle Creek, Mich., base hospital, from Fort Oglethorpe, Major HARRY M. LEE, New London.

To Rochefeller Institute for instruction in the treatment of infected wounds, and on completion *to Fort McPherson, Ga.*, for temporary duty, from Fort Oglethorpe, Lieut. JAMES A. HARTEN, New Haven.

The following order has been revoked: *To Camp Jackson*, Columbia, S. C., for duty, Lieut. HYMAN A. LEVIN, New Haven.

Delaware

To Camp Meade, Annapolis Junction, Md., for duty, from Fort Oglethorpe, Lieut. ROBERT D. HIGGINS, Wilmington.

To Camp Wadsworth, Spartanburg, S. C., for duty, Lieut. HARRY C. HICKMAN, Wilmington.

To Fort Oglethorpe for instruction, Capt. HARRISON W. HOWELL, Wilmington.

District of Columbia

To Camp Zachary Taylor, Louisville, Ky., for duty, from Walter Reed General Hospital, Major DANIEL L. BORDEN, Washington.

To New York City, Neurological Institute for intensive training, Lieut. DORRELL G. DICKERSON, Washington.

To Washington, D. C., American University, for duty, Lieut. HERBERT C. DALLWIG, Washington.

Florida

To Camp Gordon, Atlanta, Ga., for duty, from Fort Oglethorpe, Capt. HARRY B. McEUEN, Quincy.

To Camp Wadsworth, Spartanburg, S. C., for duty, from Fort Oglethorpe, Lieut. RALPH J. GREENE, Loughridge.

To Fort McPherson, Ga., for temporary duty, Capt. WILLIAM S. MANNING, Jacksonville.

To Fort Oglethorpe for instruction, Capt. J. BROWN WALLACE, Tampa; Lieuts. EVANS L. HUGGINS, Freeport; RAYMOND D. TOMPKINS, Jasper; JOHN C. WINSON, Tampa; from Camp Joseph E. Johnston, Lieut. ODIS G. KENDRICK, Tallahassee.

Georgia

To Camp Devens, Ayer, Mass., for duty, from Fort Oglethorpe, Capt. DANIEL B. EDWARDS, Savannah.

To Camp Jackson, Columbia, S. C., base hospital, Lieut. MORTIMER A. EHRLICH, Swainsboro.

To Camp Joseph E. Johnston, Jacksonville, Fla., for duty, Capt. SAMUEL A. CLARK, Eatonton; Lieuts. GEORGE O. ALLEN, Fargo; OLIN S. COFER, Smyrna.

To Camp Lee, Petersburg, Va., for duty, from Fort Oglethorpe, Lieut. THOMAS R. MOYE, Alapaha.

To Camp Meade, Annapolis Junction, Md., for duty, from Camp Pike, Capt. RICHARD T. O'NEIL, Atlanta; from Fort Oglethorpe, Lieut. EDWIN N. SMAUER, Atlanta.

To Camp Sevier, Greenville, S. C., base hospital, Lieut. HARRY B. BRADFORD, Atlanta.

To Camp Shelby, Hattiesburg, Miss., base hospital, from Camp Gordon, Major JAMES E. PATLIN, Atlanta.

To report by wire to the Governor of the State of Georgia, as medical adviser, from Camp Hancock, Major WILLIAM C. LYLE, Augusta.

To Rochefeller Institute for instruction in the treatment of infected wounds, and on completion *to Camp Dix*, Wrightstown, N. J., base hospital, from Fort Oglethorpe, Lieut. HAMPTON M. BARKER, Flintstore. On completion *to Williamsbridge, N. Y.*, for duty, Lieut. CHARLES E. WAITS, Atlanta.

To San Francisco, Cal., for instruction, and on completion *to his proper station*, from Camp Cody, Capt. WILLIAM B. OZEAR, Savannah.

Resignation of Lieut. CARL B. WELCH, Tifton, accepted.

Idaho

To San Francisco, Cal., for instruction, and on completion *to his proper station*, from Camp Cody, Capt. CHARLES H. SPRAGUE, Pocatello.

Illinois

To Army Medical School for instruction, from Camp MacArthur, Lieut. CLIFFORD E. BORGIN, Chicago.

To Boston, Mass., Harvard Graduate School of Medicine, for instruction, from Fort Riley, Capt. CARL G. S. RYDIN, Chicago.

To Camp Custer, Battle Creek, Mich., base hospital, Capt. HAMMER C. IRWIN, Springfield. As a member of the board examining the troops for cardiovascular diseases, Capt. NEWELL C. GILBERT, Chicago. As orthopedic surgeon from Army Medical School, Lieut. RUSSELL A. GILMORE, Chicago.

To Camp Devens, Ayer, Mass., base hospital, Lieut. HARRY E. PRUDDEN, Pecatonica. For duty, from Fort Oglethorpe, Lieuts. LEWIS K. EASTMAN, JACOB V. KAHN, Chicago.

To Camp Grant, Rockford, Ill., as orthopedic surgeon, from Chicago, Lieut. MIECISLAUS H. KOSTRZEWSKI, Chicago. Base hospital, from Chicago, Lieut. HARRY S. SULLIVAN, Chicago. For duty, from Camp Custer, Lieut. HOWARD S. PERRY, Chicago.

To Camp Greene, Charlotte, N. C., base hospital, from Army Medical School, Lieut. FRANK X. MOCK, Chicago.

To Camp Jackson, Columbia, S. C., as orthopedic surgeon, from Chicago, Lieut. ELVEN BERKEISER, Aurora. Base hospital, Lieuts. HARRY SERED, NICHOLAS C. STAM, Chicago. For duty, from Fort Oglethorpe, Lieut. CLARENCE E. FRYBERGER, Oak Park.

To Camp Joseph E. Johnston, Jacksonville, Fla., for duty, from Fort Oglethorpe, Capt. FREDERICK I. BROWN, Chicago.

To Camp Kearny, Linda Vista, Calif., with the board examining the command for nervous and mental diseases, from Fort Riley, Lieut. ELMER L. CROUCH, Jacksonville.

To Camp Lee, Petersburg, Va., for duty, from Camp Devens, Capt. JOHN G. FROST, Chicago; Lieut. FRANK E. SHIPMAN, Paris.

To Camp Lewis, American Lake, Wash., for duty, from Fort Riley, Lieut. EDWARD W. SIKES, Freeport.

To Camp Meade, Annapolis Junction, Md., for duty, from Camp Devens, Lieut. JOHN W. MARTIN, Oliver; from Fort Oglethorpe, Lieut. AMBLER C. PRUNER, Chicago.

To Camp Pike, Little Rock, Ark., for duty, from Fort Riley, Capt. IRA J. SCOTT, Danville; Lieuts. FRANKLIN W. PALMER, Chatsworth; OLIVER I. STATLER, Huntley.

To Fort Leavenworth, Kan., for duty, Lieut. HARVEY T. LITTLE, Chicago.

To Fort McPherson, Ga., for duty, Lieut. LOUIS M. GREENBURG, Chicago.

To Fort Monroe, Va., for temporary duty, from Fort Riley, Capt. REUBEN J. ATWOOD, Chicago.

To Fort Oglethorpe as instructor, from Chicago, Major JOHN RIDLON, Chicago; from New York City; Capt. EDWARD S. BLAINE, Chicago. For instruction, Capts. ARTHUR M. PURVES, Des Plaines; CORYDON DEK. BUNDY, Sadorus; Lieuts. JAMES V. ANDERSON, STEPHEN CZAJKOWSKI, PHILIP B. GREENBERG, JAMES T. GREGORY, REUBEN C. HANCHETT, CLAUDE A. LINK, LEONARD F. SKLERA, JAMES STEVENSON, GEORGE L. VENABLE, Chicago; ELMER L. NYSTROM, Peoria; from San Antonio, Lieut. IRVING W. STEINER, Harvey.

To Fort Sam Houston, Texas, for duty, from Camp Beauregard, Lieut. STEPHEN C. BRADLEY, Marshall; from Camp MacArthur, Lieut. RAYMOND E. HILLMER, La Grange.

To Fort Screven, Ga., with the board examining the command for nervous and mental diseases, from Camp Shelby, Lieut. WALTER C. COOK, Peoria.

To Lakehurst, N. J., for duty, from Camp Dix, Lieut. RELZA N. SHERMAN, Fairmount.

To Lakewood, N. J., for temporary duty, Lieut. SAMUEL B. LEISER, Herscher.

To New Haven, Conn., for duty, Lieuts. OSCAR COHEN, Joliet; JAMES M. MORAN, JACOB SCHLESINGER, Oak Forest.

To Philadelphia, Pa., Medical Arts Building, for instruction, from New York City, Lieut. RAYMOND E. DAVIES, Chicago.

To Plattsburg Barracks, N. Y., for duty, from Lakewood, Major DANIEL A. STEELE, Chicago.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion *to Camp Gordon*, Atlanta, Ga., base hospital, Lieut. GEORGE D. J. GRIFFIN, Chicago. On completion *to his proper station*, from Camp Grant, Lieut. JOHN M. BERGER, Chicago.

To Rochefeller Institute for instruction in the treatment of infected wounds, and on completion *to Camp Gordon*, Atlanta, Ga., base hospital, Lieut. PAUL E. GREENLEAF, Bloomington.

To San Diego, Calif., Signal Corps Aviation School, for duty, from San Francisco, Capt. FRANK A. STOCKDALE, Coal City.

To San Francisco, Calif., Letterman General Hospital, for temporary duty, from Camp Fremont, Lieut. FRANK J. SCHICK, Chicago.

To Washington, D. C., for duty in the Surgeon-General's Office, from Camp Travis, Lieut. EUGENE S. TALBOT, Chicago.

Resignation of Lieut. ALONZO T. GRIFFIN, Centralia, accepted.

The following order has been revoked: *To Camp Colt*, Gettysburg, Pa., for duty, Lieut. MORRIS B. KARATZ, Chicago.

Indiana

To Camp Lee, Petersburg, Va., for duty, from Fort Oglethorpe, Lieut. JOHN F. DOWNING, Yorktown.

To Camp Travis, Fort Sam Houston, Texas, for duty, Lieut. GEORGE M. COOK, Monroeville.

To Fort Benjamin Harrison, Ind., for duty, Capt. MALACHI P. COMBS, Terre Haute; from Camp Dix, Capt. GEORGE C. VAN MATER, Peru.

To Fort Oglethorpe for instruction, Capt. GEORGE H. VAN KIRK, Kentland; Lieuts. OLIVER M. JOHNSON, Kokomo; JOSEPH A. STOECKINGER, Mishawaka.

To Fort Sam Houston, Texas, for duty, from Camp Beauregard, Capt. JAMES A. WORK, Jr., Elkhart.

To Fort Warren, Mass., for duty, Capt. LUKE P. V. WILLIAMS, Whiteland; Lieut. WILLIAM T. FISHER, Shelbyville.

To Hoboken, N. J., for duty, from Camp Meade, Lieuts. HERMAN H. GICK, Indianapolis; OLIVER E. GRIEST, Lafayette.

To Jackson Barracks, La., for duty, Lieut. MORA S. BULIA, Richmond.

To San Francisco, Calif., for instruction, and on completion *to his proper station*, from Camp Cody, Capt. BUDD VAN SWERINGEN, Fort Wayne.

Iowa

To Boston, Mass., Harvard Graduate School of Medicine, for instruction, from Fort Riley, Capt. HARRY J. SCHOTT, Sioux City.

To Camp Forrest, Chickamauga Park, Ga., for duty, Capt. ERIE D. TOMPKINS, Clarion.

To Camp Jackson, Columbia, S. C., for duty, from Dansville, Lieut. MILTON A. GIVEN, Des Moines.

To Camp Lee, Petersburg, Va., base hospital, from Fort Oglethorpe, Capt. CALVIN W. HARNED, Des Moines. For duty, from Fort Riley, Lieut. JOHN R. CHRISTENSEN, Eagle Grove.

To Camp Lewis, American Lake, Wash., for duty, from Douglas, Lieut. ARTHUR L. DRUET, Larchwood.

To Camp Meade, Annapolis Junction, Md., for duty, from Fort Oglethorpe, Capt. GEORGE R. HILL, Charter Oak.

To Camp Pike, Little Rock, Ark., as orthopedic surgeon, from Boston, Capt. EARL D. McCLEAN, Oskaloosa. For duty, Lieut. RAYMOND L. LATCHEM, Walnut.

To Fort Leavenworth, Kan., for duty, Lieut. DAVID M. NYQUIST, Elkhorn.

To Fort Oglethorpe for instruction, Capts. NELSON McP. WHITEHILL, Boone; ERIE D. TOMPKINS, Clarion.

To Hoboken, N. J., for duty, Lieut. CHESTER H. JOHNSON, Cherokee; from Camp Grant, Lieut. ELLIOTT S. STRONG, Iowa City.

Kansas

To Camp Dodge, Des Moines, Ia., base hospital, from Fort Riley, Lieut. FRANCIS J. MOFFATT, Clyde.

To Camp Gordon, Atlanta, Ga., base hospital, from Fort Oglethorpe, Lieut. LOT D. MABIE, Kansas City.

To Camp Jackson, Columbia, S. C., base hospital, from Fort Riley, Lieut. GUY A. FINNEY, Wamego.

To Camp Pike, Little Rock, Ark., for duty, Lieuts. JAMES A. FULTON, Kansas City; JOHN R. CRAWFORD, Tonganoxie.

To Camp Zachary Taylor, Louisville, Ky., base hospital, Capt. GORDON M. GAFFORD, Kinsley.

To Fort Oglethorpe for instruction, Lieuts. EDWARD D. RODDA, Arma; WILLIAM O. WHITAKER, Wichita.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion *to Camp Dodge*, Des Moines, Ia., base hospital, Lieut. FREDERICK P. MANN, Valley Falls.

To San Francisco, Calif., for duty, from Fort Riley, Capt. LEONARD S. STEADMAN, Junction City.

Kentucky

To Camp Holabird, Colgate, Md., for duty, from Camp Beauregard, Major PHILIP H. STEWART, Paducah.

To Camp Joseph E. Johnston, Jacksonville, Fla., for duty, from Fort Oglethorpe, Lieut. BERTON M. BROWN, Quicksand.

To Camp Lee, Petersburg, Va., for duty, from Camp Sheridan, Capt. GUY P. GRIGSBY, Louisville; from Fort Oglethorpe, Capt. SIDNEY J. ANDERSON, Midway; Lieut. THOMAS H. NELSON, Covington.

To Camp Meade, Annapolis Junction, Md., for duty, from Fort Oglethorpe, Lieut. OLIVER P. HENRY, Kildan.

To Camp Sherman, Chillicothe, Ohio, for duty, Lieut. TRAVIS D. RUDD, Hopkinsville.

To Camp Wadsworth, Spartanburg, S. C., for duty, Lieut. EARL J. EVERSOLE, Simpsonville; from Fort Oglethorpe, Lieut. EDGAR C. HAWKINS, Emmett.

To Fort Hoyard, N. H., for temporary duty, from Fort Monroe, Capt. JAMES R. PEABODY, Louisville.

To Fort Benjamin Harrison, Ind., for duty, Lieut. WILLIAM M. EWING, Cave City.

To Fort Oglethorpe for instruction, Capt. JOHN KING FREEMAN, Louisville.

To Fort Thomas, Ky., with the board examining the command for nervous and mental diseases, Lieut. AVONIA E. KISER, Paris.

To Lakewood, N. J., for temporary duty, Lieut. JOSEPH C. MONNIER, Louisville.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion *to Camp Dodge*, Des Moines, Ia., base hospital, from Fort Oglethorpe, Lieut. DAVID H. BUSH, Mt. Sterling.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion *to Bellevue Hospital*, for further instruction, and on completion *to his proper station*, from Camp Logan, Major JOHN H. BLACKBURN, Bowling Green.

Louisiana

To Camp Sherman, Chillicothe, Ohio, as member of the board examining the command for tuberculosis, from Camp Shelby, Lieut. EWELL A. KLEINPETER, Thibodaux.

To Fort Oglethorpe for instruction, Lieut. ALBERT S. COOPER, Mansfield. For instruction in orthopedic surgery, from Washington, Capt. JOHN T. O'FERRALL, New Orleans.

To report to the commanding general, Philippine Department, for duty, from Camp Shelby, Lieut. HENRY C. LOCHTE, New Orleans.

The following order has been revoked: *To Fort Oglethorpe* for instruction, Capt. SAMUEL J. BAKER, Madisonville.

Maine

To Fort Oglethorpe for instruction, Lieut. LOREN F. CARTER, Bangor.

To Fort Warren, Mass., for duty, Lieut. LEO F. HALL, Lewiston.

To Manheim, Pa., for duty, from Camp Sevier, Lieut. CHARLES B. SYLVESTER, Harrison.

To Walter Reed General Hospital, Takoma Park, D. C., for duty, from Camp Dodge, Capt. HORACE K. RICHARDSON, Bradford.

Maryland

To Aberdeen, Md., for duty, from Camp Jackson, Lieut. JAY H. STIER, Perryman.

To Army Medical School for instruction, from Camp Wheeler, Lieut. CLARENCE W. REDDIG, Baltimore.

To Camp Grant, Rockford, Ill., base hospital, Lieut. JAMES J. CHISOLM, Baltimore.

To Camp Jackson, Columbia, S. C., base hospital, Lieut. EARL H. DORGE, Baltimore; from Camp Bowie, Lieut. HOWARD L. WHEELER, Baltimore.

To Camp Lee, Petersburg, Va., base hospital, Lieuts. VINCENT T. SHIPLEY, Baltimore; HENRY B. RICHARDSON, Windsor Hills.

To Fort McPherson, Ga., for duty, Lieut. FRANKLIN C. BLEDER, Baltimore.

To Fort Oglethorpe for instruction, Lieuts. GEORGE G. E. CROSS, CHARLES S. NEISTADT, Baltimore; WILLIAM C. CHANEY, Chaney; from Camp A. A. Humphreys, Lieut. JOSEPH E. NORRIS, Baltimore.

To Fort Sam Houston, Texas, for duty, from Fort Thomas, Lieut. HENRY E. AUSTIN, Baltimore; from New York City, Capt. FRANK N. HOFFMEIER, Hagerstown.

To New Haven, Conn., for duty, Lieuts. PAUL W. CHRISTMAN, ALBERT EISENBERG, Baltimore.

To New York City, Cornell Medical College, for instruction, and on completion *to his proper station*, from Army Medical School, Major HOWARD E. ASHBURY, Baltimore.

Massachusetts

To Boston, Mass., for consultation, and on completion *to his proper station*, from Walter Reed General Hospital, Major FREDERIC J. COTTON, Boston; Harvard Graduate School of Medicine, for instruction, Lieut. ARMIN KLEIN, Boston.

To Camp Jackson, Columbia, S. C., base hospital, Lieut. GEORGE A. CLARK, Holyoke; from Chicago, Capt. CLARENCE H. DOBSON, Conway.

To Camp Joseph E. Johnston, Jacksonville, Fla., as orthopedic surgeon, from Army Medical School, Lieut. CARL BEARSE, Boston. To examine the command for nervous and mental diseases, from Camp Shelby, Lieut. FRANCIS S. CALDICOTT, Milford.

To Camp Lee, Petersburg, Va., base hospital, from Surgeon-General's Office, Lieut. FREDERIC B. M. CADY, Cambridge. For duty, from Camp Devens, Lieut. WILLIAM J. DILLON, Springfield.

To Camp Meade, Annapolis Junction, Md., base hospital, Lieut. JAMES M. McTIERNAN, Quincy.

To Camp Upton, L. I., N. Y., with the board examining the command for nervous and mental diseases, Capt. HANSOM A. GREENE, Palmer.

To Camp Wadsworth, Spartanburg, S. C., base hospital, from Fort Oglethorpe, Capt. JAMES R. TORBERT, Boston.

To Camp Zachary Taylor, Louisville, Ky., base hospital, from Fort Oglethorpe, Capt. ERNEST B. YOUNG, Boston. For duty, from Camp Lee, Lieut. EARLE H. MacMICHAEL, Malden.

To Fort McHenry, Md., for duty, from Fort H. G. Wright, Capt. FRANK A. DAVIS, Boston.

To Fort McPherson, Ga., for duty, Lieut. FREDERICK PARKER, Jr., Bedford.

To Fort Oglethorpe for instruction, Capts. ALFRED C. SMITH, Brockton; GEORGE H. MAXFIELD, Chelsea; Lieut. CARL C. PERSONS, Maynard.

To Fort Sam Houston, Texas, for duty, from Camp Beauregard, Capt. CHARLES F. CANEDY, Greenfield.

To Hoboken, N. J., for duty, from Army Medical School, Capt. ARTHUR M. WORTHINGTON, Dedham; from Camp Devens, Lieut. WILLIAM A. MONCRIEFF, New Bedford.

To Lakewood, N. J., for duty, from the Surgeon-General's Office, Major FRANCIS W. PEABODY, Cambridge; from Camp Gordon, Lieut. THOMAS McC. MABON, Boston. For temporary duty, Lieut. JOSEPH T. WEARN, Boston.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion *to Camp Devens*, Ayer, Mass., base hospital, Capt. JOHN HOMANS, Brookline. On completion *to Camp Upton, L. I., N. Y.*, base hospital, from Fort Oglethorpe, Lieut. EDWARD H. EWING, Stoughton.

To Washington, D. C., for consultation, and on completion to Boston, Mass., for duty, and on completion *to Cape May, N. J.*, base hospital, from Cape May, Capt. HARRY F. CAHILL, Boston. For temporary duty, and on completion *to the inactive list*, from Camp Meade, Major SAMUEL J. MIXTER, Boston.

The following order has been revoked: *To Camp Hancock*, Augusta, Ga., with the board examining the troops for cardiovascular diseases, from Fort Oglethorpe, Lieut. HARRY A. WALKER, Somerville.

Michigan

To Baltimore, Md., Curtis Bay, for duty, from Fort Oglethorpe, Lieut. JOHN K. BURNS, Jr., Detroit.

To Camp Custer, Battle Creek, Mich., as orthopedic surgeon, from Army Medical School, Lieut. ROBERT H. BAKER, Ann Arbor. Base hospital, Lieut. ROLAND S. CRON, Ann Arbor. For duty, Lieut. LEROY E. HULL, Detroit.

To Camp Devens, Ayer, Mass., for duty, from Fort Oglethorpe, Lieut. DANIEL R. DONOVAN, Detroit.

To Camp Dix, Wrightstown, N. J., for duty, from Fort Oglethorpe, Capt. HUGH McL. BEEBE, Ann Arbor.

To Camp Grant, Rockford, Ill., for duty, from Camp Dodge, Lieut. GROVER C. WOOD, Detroit.

To Camp Greene, Charlotte, N. C., as a member of the board examining the command for tuberculosis, from Camp Shelby, Lieut. JOHN J. MILLER, Berlin.

To Camp Hancock, Augusta, Ga., base hospital, from Fort Oglethorpe, Lieut. GORDON H. YEO, Big Rapids.

To Camp Jackson, Columbia, S. C., for duty, from Fort Oglethorpe, Lieut. WILLIAM J. KANE, Detroit.

To Camp Lee, Petersburg, Va., for duty, Lieut. JAMES M. SEVERSON, Detroit.

To Camp Meade, Annapolis Junction, Md., for duty, Capt. FLOYD W. CLEMENTS, Detroit.

To Camp Pike, Little Rock, Ark., for duty, Lieut. LEON J. GIBSON, Bay City.

To Camp Sherman, Chillicothe, Ohio, base hospital, Capt. RAYMOND D. SLEIGHT, Battle Creek.

To Camp Wheeler, Macon, Ga., with the board examining the command for cardiovasculahr diseases, from Camp Sevier, Lieut. CHARLES E. LEMMON, Detroit.

To Cape May, N. J., base hospital, from Fort Oglethorpe, Lieut. WILLIAM R. McCLURE, Detroit.

To Hoboken, N. J., for temporary duty, from New York City, Capt. EUGENE B. STEBBINS, Ironwood.

To Ithaca, N. Y., Cornell University, for duty, from Mount Clemens, Capt. ROBERT V. GALLAGHER, Battle Creek.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion *to Camp Zachary Taylor*, Louisville, Ky., base hospital, Lieut. THOMAS E. HACKETT, Jackson.

Minnesota

To Camp Dodge, Des Moines, Ia., as a member of the board examining the troops for cardiovascular diseases, Lieut. MORSE J. SHAPIRO, Minneapolis.

To Camp Grant, Rockford, Ill., for duty, from Jefferson Barracks, Capt. EARL H. MARCUM, Bemidji; from duty as a contract surgeon, Capt. RALPH S. MORRIS, Minneapolis.

To Camp Jackson, Columbia, S. C., for duty, from Camp Sherman, Lieut. ADOLPH E. DETUNCO, Preston.

To Camp Kearny, Linda Vista, Calif., with the board examining the command for nervous and mental diseases, from Fort Riley, Lieut. ABRAHAM J. MILLER, Sleepy Eye.

To Camp McClellan, Anniston, Ala., base hospital, from New York City, Lieut. PAUL S. EPPERSON, Siwabik.

To Camp Meade, Annapolis Junction, Md., for duty, from Camp Lee, Lieut. CARL COWIN, Minneapolis; from Camp Sherman, Lieut. JOHN J. DONOVAN, Hutchfield.

To Fort Oglethorpe for instruction, Capt. THOMAS E. FLINN, Redwood Falls; Lieuts. BERNARD N. SOROSE, Detroit; THOMAS J. TRUTNA, Silver Lake; HAROLD E. HALLSICK, St. Paul.

To Fort Sam Houston, Texas, for duty, from Camp MacArthur, Lieut. DELPHIN W. KOHLER, Albany; from Camp Meade, Capt. WILLIAM V. LINDSAY, Winona.

To Fort Sheridan, Ill., as orthopedic surgeon, from Fort Oglethorpe, Capt. JAMES A. McLAUGHLIN, Minneapolis.

To Minneapolis, Minn., for duty, Capt. RALPH ST. J. FERRY, Minneapolis.

To Portland, Ore., Yeon Building, for duty, Lieut. ARTHUR A. WOHLRABE, Mankato.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion *to his proper station*, from Camp Dodge, Capt. FRANK M. MANSON, Worthington. On completion *to Camp Sherman*, Chillicothe, Ohio, base hospital, Lieut. JOHN B. DOYLE, St. Paul.

The following order has been revoked: *To Camp Greene*, Charlotte, N. C., base hospital, from Hoboken, Lieut. JOSEPH C. MICHAEL, St. Paul.

Mississippi

To Fort Oglethorpe for instruction, Capt. JOHN R. KITTRELL, Laurel; Lieuts. CARL A. DAY, Bentonia; JESSE R. STAMPER, Decatur; ROBERT GOING, Vicksburg.

To the inactive list, from Camp Hancock, Lieut. FRANK S. HILL, Grenada.

Missouri

To Army Medical School for instruction, Lieut. BENJAMIN W. LEWIS, St. Louis.

To Camp Custer, Battle Creek, Mich., as orthopedic surgeon, from Chicago, Lieut. LEON V. URBANOWSKI, St. Louis. Base hospital, from Kansas City, Capt. CALVIN L. COOPER, Kansas City.

To Camp Devens, Ayer, Mass., base hospital, Lieuts. HUGH G. McKAY, Bangor; WILBUR K. BROWN, St. Louis.

To Camp Gordon, Atlanta, Ga., for duty, from Camp Wheeler, Lieut. WILLIAM F. MITCHELL, St. Louis.

To Camp Grant, Rockford, Ill., for duty, from Camp Custer, Lieut. FRED E. DARGATZ, Kansas City.

To Camp Jackson, Columbia, S. C., as orthopedic surgeon, from Chicago, Lieut. CHARLES F. DAVIS, Kansas City. Base hospital Lieuts. DAVID F. FERRIS, ALEXANDER C. KIRBY, St. Louis; from Camp Sherman, Capt. ORRIL LeG. SUGGETT, St. Louis.

To Camp Lewis, American Lake, Wash., for duty, from Fort Riley, Capt. OTTO L. MUENCH, Washington; Lieut. GOUGH H. TARR, Coplar; GEORGE B. PENNINGTON, West Walton.

To Camp McClellan, Anniston, Ala., base hospital, Capt. FRANK McD. DENSLOW, Kansas City.

To Camp Meade, Annapolis Junction, Md., for duty, Lieut. ALVIN H. DIEHR, St. Charles; from Fort Oglethorpe, Lieut. ERNEST M. McKENZIE, St. Louis.

To Fort McPherson, Ga., for duty, Capt. WILLIAM P. GLENNON, St. Louis.

To Fort Oglethorpe for instruction, Capt. CHARLES A. STONE, St. Louis; Lieuts. EZRA L. MEADS, Bonnots Mill; GERHARD KAEMMERLING, Joplin; NATHAN ZOGLIN, Kansas City; KENNETH C. PEACOCK, St. Louis; GEORGE W. ELDERS, Ware.

To Fort Riley as a member of the board examining the troops for cardiovascular diseases, Lieut. FRED B. KYGER, Kansas City.

To Fort Sam Houston, Texas, for duty, from Camp Shelby, Lieut. LOGAN L. LATHAM, Latham; from Camp Travis, Capt. JOHN S. WEAVER, Kansas City.

To Hoboken, N. J., for duty, from Camp Wadsworth, Capt. MOYER S. FLEISHER, St. Louis.

To Moberly, Mo., for duty, and on completion *to his proper station*, from St. Louis, Major WILLAM J. LUEDDE, St. Louis.

To New Haven, Conn., for duty, Lieut. HOLLIS S. THOMAS Kansas City.

To Orono, Maine, for temporary duty in connection with the examination of drafted troops at the University of Maine, and on completion *to his proper station*, from Camp Devens, Lieut. EDWARD X. LINK, St. Louis.

To Walter Reed General Hospital, Takoma Park, D. C., for duty, from Camp Greene, Capt. CHARLES H. HECKER, St. Louis.

Resignation of Lieut. CHARLES E. WOODY, Springfield, accepted.

Montana

To Camp Doniphan, Fort Sill, Okla., from Fort Logan, Lieut. JOHN J. TOBINSKI, Missoula.

To Camp Joseph E. Johnston, Jacksonville, Fla. as orthopedic surgeon, from New York City, Lieut. EARL S. PORTER, Moore.

To Camp Kearney, Linda Vista, Calif., base hospital, Lieut. JOHN L. TREACY, Helena.

To Camp Lewis, American Lake, Wash., for duty, Capt. WILLIAM G. RICHARDS, Billings.

To report for orders to the commanding general, for assignment to duty, Major FRANCIS J. ADAMS, Great Falls.

Nebraska

To Boston, Mass., Harvard Graduate School of Medicine, for instruction, from Fort Riley, Lieut. CHARLES W. WAY, Wahoo.

To Camp Lee, Petersburg, Va., with the board examining the troops for tuberculosis, from Camp Sevier, Lieut. TORRENCE C. MOYER, Lincoln.

To Camp Meade, Annapolis Junction, Md., for duty, Lieut. DANIEL W. JONES, Omaha.

To Camp Travis, Fort Sam Houston, Texas, as orthopedic surgeon from Chicago, Lieut. LESTER K. STRATE, Sutton.

To Chicago, Ill., Northwestern University Medical School for instruction, from Fort Riley, Capt. FRANK L. FRINK, Norman Grove.

To Fort Des Moines, Ia., base hospital from Camp Pike, Lieut. WILLIAM R. PETERS, Stanton.

To Fort Oglethorpe for instruction, Lieuts. EARL C. MONTGOMERY, ARTHUR J. ROSS, Omaha.

Nevada

To Camp Lewis, American Lake, Wash., for duty, Lieut. CLAUDE H. CHURCH, Tenopah.

New Hampshire

To Camp Forrest, Chickamauga Park, for duty, from Philadelphia, Lieut. MELVIN P. BADGER, Manchester.

To Camp Shelby, Hattiesburg, Miss., base hospital, from New York City, Lieut. RALPH S. PERKINS, Exeter.

To Fort Oglethorpe for instruction, Lieut. ALBERT P. MULVANITY, Nashua.

To Jefferson Barracks, Mo., as a member of the board examining the command for nervous and mental diseases, Lieut. LOUIS O. S. WALLACE, Concord.

New Jersey

To Camp Jackson, Columbia, S. C., base hospital, Lieut. JOSEPH D. LATHAM, Atlantic City; from Mount Clemens, Lieut. IRVING E. INGBRAM, Secaucus. For duty, from Camp Dix, Lieut. BROOKE DODSON, Penn's Grove; from Camp Shelby, Lieut. FRANK J. McLOUGHLIN, Jersey City.

To Camp Lee, Petersburg, Va., for duty, from Camp Dix, Capt. THOMAS A. CLAY, Paterson.

To Camp Meade, Annapolis Junction, Md., for duty, from Fort Oglethorpe, Lieut. BENJAMIN J. SILVERSTEIN, Newark.

To Cape May, N. J., base hospital, from Camp Dix, Capt. ELLERY M. PECK, Boonton.

To Edgewood, Md., base hospital, Lieut. JOHN J. MACDONALD, Jersey City.

To Fort Oglethorpe for instruction, Capt. JOHN A. HOLLAND, Montclair; Lieuts. MAURICE CHESLER, Atlantic City; THOMAS L. CALDRONEY, DONALD A. CURTIS, Hackensack; FREDERICK H. VON HOPE, Orange; GEORGE E. GALLAWAY, Rahway.

To Fort Riley as a member of the board examining the command for tuberculosis, from Camp Sheridan, Lieut. HOWARD S. SMITH, Newark.

To Fort Sam Houston, Texas, for instruction, and on completion *to his proper station*, from Camp Logan, Lieut. THOMAS W. HARVEY, Ja., Orange.

To Fort Warren, Mass., for duty, Lieut. WILLIAM R. TILTON, South Amboy.

To Hoboken, N. J., for duty, from Fort Oglethorpe, Lieut. GEORGE F. MURMANE, Passaic.

To Lincoln, Neb., University of Nebraska, for duty, from Fort Oglethorpe, Capt. ABIJAH O. BUCK, Elizabeth.

To Medford, Mass., Tufts Medical College, to make physical examinations and give medical atention to the drafted men enrolled at this institution, from Fort Oglethorpe, Lieut. ABRAHAM G. REINFIELD, Newark.

To Walter Reed General Hospital, Takoma Park, D. C., for duty, Lieut. WILLIAM RAIM, Jersey City.

The following orders have been revoked: *To Chicago, Ill.* for instruction, from Fort Oglethorpe, Lieut. ALEXANDER J. McRAE, Upper Montclair. *To Fort Oglethorpe* for duty, Lieut. ADFUR E. HAINES, Jersey City. *To Takoma Park, D. C.*, to make physical examinations and give medical attention to the drafted men to be enrolled at this institution, and on completion *to his proper station*, from Army Medical School, Lieut. THOMAS W. CONNOLLY, Jersey City.

New Mexico

To Camp Pike, Little Rock, Ark., for duty, from Fort Riley, Lieut. ROBERT T. LUCAS, Carrizozo.

To Fort Oglethorpe for instruction, Lieut. GEORGE V. HACKNEY, Magdalena.

New York

To Army Medical School for instruction, Lieuts. GEORGE P. McNEILL, Jr., WALTER VAN O. MOORE, New York; from Fort Sam Houston, Lieut. ROBERT BOGAN, New York; from Fort Slocum, Lieut. JOHN L. HEMSTEAD, Albany.

To Biltmore, N. C., for temporary duty, Lieut. LYMAN H. WHEELER, Lockport.

To Boston, Mass., Harvard Graduate School of Medicine, for instruction, Capt. JOSEPH L. BENDELL, Albany.

To Camp Dix, Wrightstown, N. J., base hospital, from Camp Pike, Capt. RAE W. WHIDDEN, New York. For duty, from Camp Devens, Lieut. JAMES P. DOUGHERTY, Brooklyn; from Camp Upton, Lieut. FREDERIC N. WILSON, New York; Lieuts. ARTHUR C. SMITH, Elmira; IRA W. LIVERMORE, Gowanda; from Chanute Field, Lieut. LINN V. H. REED; from New York, Lieut. BERNARD S. STRAIT, Penn Yan.

To Camp Doniphan, Fort Sill, Okla., for duty, from Fort Logan, Lieut. GEORGE W. BATT, Kennedy.

To Camp Gordon, Atlanta, Ga., with the board examining the command for nervous and mental diseases, from Camp Hancock, Capt. EMIL ALTMAN, New York; Lieut. DANIEL J. SWAN, Flushing.

To Camp Grant, Rockford, Ill., for duty, from New York, Lieut. CALVIN B. WITTER, Schenectady.

To Camp Jackson, Columbia, S. C., base hospital, Lieuts. ABRAHAM KARDINER, JEROME L. KOHN, WILLIAM C. MACDONALD, New York. For duty, from Camp Bowie, Lieut. SAMUEL W. HAUSMAN, Ogdensburg; from Camp Gordon, Lieut. HARRY GOLDMANN, Long Island City; from Camp Meade, Lieut. HAROLD J. McDONALD, Buffalo. With the board examining the troops for cardiovascular diseases, from Camp A. A. Humphreys, Lieut. JOHN L. BYRNES, Hudson Falls.

To Camp Joseph E. Johnston, Jacksonville, Fla., as orthopedic surgeon, from Army Medical School, Lieut. GEORGE E. BLUE, New York. To examine the command for nervous and mental diseases, from Camp Shelby, Lieut. HYMAN HERSHBERG, New York.

To Camp Lee, Petersburg, Va., for duty, from Camp Dodge, Lieut. JOSEPH L. McGOLDRICK, Brooklyn; from Fort McPherson, Lieut. WILLIAM P. McCLOSKIN, New York; from Fort Oglethorpe, Lieut. DANIEL P. GILLESPIE, New York.

To Camp Meade, Annapolis Junction, Md., base hospital, from Army Medical School, Lieut. ETHELBERG A. CALLAGHAN, Brooklyn. For duty, Lieut. ABRAHAM LEIBOVITZ, New York; from Camp Wadsworth, Lieuts. THOMAS J. LUBY, New York.

To Camp Raritan, Metuchen, N. J., for duty, from Fort Oglethorpe, Lieut. THOMAS M. CALLADINE, Perry.

To Camp Sevier, Greenville, S. C., for duty, from Camp Jackson, Capt. ARTHUR H. GREENWOOD, New York.

To Camp Sheridan, Montgomery, Ala., base hospital, Capt. THOMAS H. CURTIN, New York.

To Camp Sherman, Chillicothe, Ohio, as a member of the board examining the command for tuberculosis, from Fort Riley, Lieut. CARL G. FROST, Buffalo.

To Camp Wadsworth, Spartanburg, S. C., for duty, Lieut. MATTHEW A. LIOTTA, New York; from Fort Myer, Lieut. BENJAMIN RABBINER, Brooklyn; from Fort Oglethorpe, Lieut. HAROLD MacM. JOHNSON, Friendship.

To Camp Wheeler, Macon, Ga., base hospital, from Fort Oglethorpe, Capt. JOHN C. HOWARD, Blackwell's Island; from Fort Screven, Lieut. PERCY L. DODGE, Poughkeepsie.

To Camp Zachary Taylor, Louisville, Ky., for duty, from Walter Reed General Hospital, Capt. MAURICE B. BANNETTE, Watertown.

To Cape May, N. J., base hospital, Capt. LEE M. FRANCIS, Buffalo; from Camp Beauregard, Lieut. JAMES C. SULLIVAN, Buffalo.

To Fort Benjamin Harrison with the board examining the troops for tuberculosis, from New Haven, Lieuts. MORRIS A. SAGOWITZ, EDWIN F. SAMPSON, New York.

To Fort Leavenworth, Kansas, for duty, Lieut. DANIEL JUNG, Buffalo.

To Fort McHenry, Md., base hospital, from Newport News, Lieut. JAMES D. MILLER, New York.

To Fort McPherson, Ga., for duty, from Mineola, Capt. THEODORE S. WEST, Yonkers.

To Fort Myer, Va., for duty, Capt. EDWARD B. FINCH, New York.

To Fort Oglethorpe for instruction, Lieuts. RAY H. BECHTELL, Blackwell's Island; JULIUS RYBACK, ALFRED P. STEPHANY, WALTER F. WATTON, Brooklyn; FRANCIS M. KUJAWA, Buffalo; HERMAN H. JAMES, HAROLD H. JOY, WILLIS W. LASHER, HAROLD W. NIELSON, JOHN C. O'NEILL, JAMES W. SMITH, DONALD T. TILTON, WILLIAM W. TRACY, AARON WEINBERG, New York; CLYDE L. McNEIL, Poughkeepsie; FRANCIS J. ROBINSON, Rochester; WILLIAM W. WOGLOM, Rome; HERMAN E. OAK, South Onondaga.

To Fort Porter, N. Y., for duty, from Camp Devens, Capt. CLARENCE H. MACKEY, Lancaster.

To Fort Sam Houston, Texas, for duty, from Camp MacArthur, Lieut. RAYMOND T. POTTER, Ellenville.

To Fort Thomas, Ky., for investigation, and on completion *to his proper station*, Major RICHARD H. HUTCHINGS, Ogdensburg.

To Hoboken, N. J., base hospital, Lieut. MAURICE A. BARNARD, Rochester. For duty, Lieut. LEO SIMTBAUM, Brooklyn; from Fort Oglethorpe, Lieuts. WILLIAM LIEBERMAN, Jamaica; ALFA V. SALOMON, CHARLES O. TERESI, New York.

To Lakewood, N. J., for temporary duty, Lieuts. SAMUEL KAHN, JOHN J. H. KEATING, DANIEL SCHULTKEIS, New York.

To Mineola, L. I., N. Y., Hazelhurst Field, Signal Corps Aviation School, for duty, Lieut. ROBERT BURLINGTON, New York.

To New Haven, Conn., for duty, Lieuts. JOHN J. RANDALL, Albany; JAMES H. STYGALL, Buffalo; BERNARD R. KELLEY, HARRY J. SEIFF, New York.

To Newport News, Va., with the board examining the command for nervous and mental diseases, Lieut. ABRAHAM C. SILVERMAN, Syracuse.

To Rockefeller Institute for instruction in bacteriology, and on completion *to Army Medical School*, for duty, Lieut. JOHN R. HOLDERNESS, New York. For instruction in the treatment of infected wounds, and on completion *to Camp Custer*, Battle Creek, Mich., base hospital, Lieut. EDWARD J. HYLAND, Jamaica. On completion *to Camp Devens*, Ayer, Mass., base hospital, Lieut. WILLIAM J. GALVIN, Oswego. On completion *to Camp Sevier*, Greenville, S. C., base hospital, Capt. THOMAS A. KENYON, New York. On completion *to Fort McPherson, Ga.*, for temporary duty, Lieut. ALEXANDER A. BERSIN, Brooklyn. On completion *to Walter Reed General Hospital* for temporary duty, Capt. FRANK E. BROWN, Brooklyn; Lieut. FRANK B. ORR, New York.

To Washington, D. C., for temporary duty, and on completion *to his proper station*, from Army Medical School, Lieuts. ROBERT A. CORBIN, New York; BENJAMIN J. SLATER, Rochester.

The following orders have been revoked: *To Army Medical School* for instruction, and on completion *to Boston, Mass.*, Harvard Graduate School of Medicine, for instruction, from Fort Oglethorpe, Lieut. PORTER A. STEELE, Buffalo. *To Fort Oglethorpe* for instruction, Lieuts. JULIUS RYBACK, WALTER F. WATTON, Brooklyn. *To Newport News, Va.*, for duty, Lieut. PHILIP B. BREGMAN, New York. *To Philadelphia, Pa.*, University Hospital, and on completion *to Camp Greene*, Charlotte, N. C., base hospital, Capt. GEORGE W. CONTERNO, New York.

North Carolina

To Camp Jackson, Columbia, S. C., for duty, from Fort Oglethorpe, Lieut. STEPHEN J. HAWES, Dover.

To Camp Lee, Petersburg, Va., for duty, Capt. PARKS McC. KING, Charlotte; from Fort Oglethorpe, Capt. BENJAMIN K. HAYS, Oxford; CLARENCE LaF. WILSON, Lenoir.

To Camp Wadsworth, Spartanburg, S. C., for duty, Capt. VANN McK. LONG, Winston-Salem.

To Fort Bayard, N. M., for duty, from Camp Beauregard, Lieut. RANDOLPH E. WATTS, Oriental.

To Fort Oglethorpe for instruction, Lieut. ROWLAND McN. LANCASTER, St. Pauls.

To Fort Sam Houston, Texas, for duty, from Camp Sevier, Lieut. HUGH A. THOMPSON, Raleigh.

To New Haven, Conn., for duty, Capt. THOMAS P. CHEESBOROUGH, Asheville.

North Dakota

To Camp Dodge, Des Moines, Iowa, base hospital, Lieut. EDMUND C. STUCKE, Garrison.

To Camp Lee, Petersburg, Va., for duty, Capt. MORELAND R. IRBY, Lankin.

To Camp Lewis, American Lake, Wash., base hospital, from Portland, Lieut. WILLIAM P. BALDWIN, Castleton.

To Fort Oglethorpe for instruction, from Fort Des Moines, Lieut. EDWIN L. GOSS, Carrington.

To Fort Riley, base hospital, from New York, Lieut. JOHN R. PENCE, Minot.

The following order has been revoked: *To Portland, Ore.*, for duty, from Camp Greene, Lieut. HARLEY D. NEWBY, Parker.

Ohio

To Camp Devens, Ayer, Mass., base hospital, Lieut. RUDOLPH J. GIESELER, Cincinnati. For duty, from Fort Oglethorpe, Lieuts. WILLIAM L. FOX, Akron; FRANCIS E. DENMAN, Dayton.

To Camp Dix, Wrightstown, N. J., for duty, from Fort Oglethorpe, Major WILLIAM H. LEET, Conneaut.

To Camp Gordon, Atlanta, Ga., with the board examining the command for cardiovascular diseases, Lieut. HIRAM B. WEISS, Cincinnati.

To Camp Pike, Little Rock, Ark., with the board examining the troops for cardiovascular diseases, from Camp Beauregard, Lieut. CLYDE H. CHASE, Cleveland.

To Camp Sherman, Chillicothe, Ohio, base hospital, Major CLARENCE KING, Avondale.

To Camp Wheeler, Macon, Ga., base hospital, from Fort Oglethorpe, Lieut. HAROLD E. FRUTH, Muscatine.

To Camp Zachary Taylor, Louisville, Ky., for duty, from Camp Sherman, Capt. WALTER B. TURNER, Youngstown; from Camp Wadsworth, Lieut. DONALD DeC. SLURA, La Rue.

To Cape May, N. J., base hospital, from Camp Beauregard, Lieut. SAMUEL ZIELONKA, Cincinnati; from Camp Grant, Capt. JOSEPH E. PIRRUNG, Cincinnati.

To Chicago, Ill., Northwestern University, for instruction, from Fort Riley, Lieut. RAY B. BOWEN, Toledo.

To Fort Benjamin Harrison for duty, from Fort Oglethorpe, Capt. DANIEL C. MOOR, Toledo.

To Fort Des Moines, Iowa, for duty, from Camp Grant, Major FREDERICK C. HERRICK, Cleveland.

To Fort Oglethorpe for instruction, Capts. ALVA E. SNYDER, Bryon; OWEN C. REES, Toledo; Lieuts. FRED K. READ, Akron; JOHN EUGENE TALBOTT, Alger; BARRON JOHNS, FRANK J. SAUER, Cincinnati; LESTER W. KRAUSS, VASCO E. M. OSORIA, Cleveland; FRANK E. MILLER, Wauseon; WALLACE A. ORT, Springfield; WALTER I. JENKINS, St. Paris; MARK C. HOUSTON, Urbana.

To Newport News, Va., for temporary dutyy, from Army Medical School, Lieut. CLARENCE W. BETZNER, Cincinnati.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion *to Camp Grant*, Rockford, Ill., base hospital, Lieut. LORIN G. SHEETS, Cleveland.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion *to Camp Wadsworth*, Spartanburg, S. C., base hospital, Major FRED FLETCHER, Columbus.

Oklahoma

To Camp Custer, Battle Creek, Mich., as orthopedic surgeon, from Chicago, Lieut. WALTER E. KOPPENBRINK, Bartlesville.

To Camp Jackson, Columbia, S. C., for duty, Lieut. CLIFFORD B. MANDEVILLE, Bartlesville.

To Camp Lewis, American Lake, Wash., for duty, from Fort Riley, Lieut. DAVID A. BEARD, Westville.

To Camp Meade, Annapolis Junction, Md., for duty, from Fort Des Moines, Capt. LEWIS E. EMANUEL, Chickasha.

To Camp Pike, Little Rock, Ark., for duty, Capt. HARRY E. BREESE, Henryette; VIRGIL H. BARTON, McAlester.

To Camp Shelby, Hattiesburg, Miss., base hospital, Lieut. EDWARD F. STROUD, Tulsa.

To Fort Oglethorpe for instruction, Lieuts. ARTHUR E. HALE, Alva; HENRY S. DRUMMOND, Hailyville; ARTHUR F. HOBBS, Hinton; CHARLES C. SHAW, WILL C. WHIT, McAlester; CARL L. McCALLUM, Sapulpa; VICTOR M. GORE, Taloga; RALPH A. WORKMAN, Woodward.

To Fort Sam Houston, Texas, for duty, from Camp MacArthur, Major ROBERT M. HOWARD, Oklahoma City.

To Jackson Barracks, La., for duty, Lieut. HAROLD C. BRADLEY, Oklahoma City.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion *to Camp Gordon*, Atlanta, Ga., base hospital, Capt. HORACE REED, Oklahoma City.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion *to Camp Greene*, Charlotte, N. C., base hospital, Capt. JOHN H. WHITE, Muskogee.

Oregon

To Camp Lewis, American Lake, Wash., base hospital, Lieut. FRANK P. FIREY, Portland. For duty, Capt. CYLDE T. HOCKETT, Enterprise; Lieuts. ROBERT W. STEARNS, Medford; JOHN W. McCOLLOM, Portland; RUDOLPH E. KLEINSORGE, Silverton.

To Camp Meade, Annapolis Junction, Md., for duty, from Fort Des Moines, Lieut. RICHARD F. JAMES, Portland.

To Camp Pike, Litle Rock, Ark., for duty, from Fort Riley, Lieut. SAM F. LEFEVRE, Bridal Veil.

To Camp Zachary Taylor, Louisville, Ky., for duty, from Camp Lewis, Capt. EUGENE W. ROCKEY, Oswego.

To Fort Oglethorpe for instruction, Capt. CLARENCE J. McCUSKER, Portland.

Pennsylvania

To Army Medical School for instruction, Lieuts. WHITMAN C. McCONNELL, Erie; GEORGE M. UNDERWOOD, Philadelphia; from Camp McClellan, Lieut. GEORGE A. BROWN, Philadelphia; from Camp Pike, Lieut. JOHN M. WELCH, Philadelphia. On completion *to Boston, Mass.*, Harvard Graduate School of Medicine, for instruction, from Camp Gordon, Lieut. JOHN P. MAUS, Philadelphia.

To Camp A. A. Humphreys, Accotink, Pa., base hospital, from Army Medical School, Lieut. ROBERT D. SPENCER, Philadelphia; FRED B. HARRINGTON, Pittsburgh. For duty, from Camp Wadsworth, Capt. SIGMAN L. GANS, Philadelphia.

To Camp Devens, Ayer, Mass., base hospital, Lieuts. FRANK D. LEVY, Philadelphia; HAROLD F. MOFFITT, Pittsburgh.

To Camp Dix, Wrightstown, N. J., base hospital, from Rockefeller Institute, Lieut. DAVID B. HAWKINS, Philadelphia. For duty, from Camp Meade, Capt. HARRY S. CARMANY, Philadelphia.

To Camp Dodge, Des Moines, Iowa, as orthopedic surgeon, Lieut. AUSTIN L. CORT, Wilson.

To Camp Grant, Rockford, Ill., for duty, from Camp Dodge, Lieut. JOHN P. DUGGAN, Pittsburgh; from Camp Jackson, Lieut. WILLIAM M. DONOVAN, Philadelphia. With the board examining the troops for cardiovascular diseases, from Jefferson Barracks, Lieut. THOMAS G. JENNY, Pittsburgh.

To Camp Jackson, Columbia, S. C., base hospital, Lieuts. WALTER R. LIVINGSTON, Philadelphia; OWEN H. BINKLEY, HARRY A. HOLLAND, JAMES S. LOGAN, JAMES M. MILLER, Pittsburgh. For duty, from Camp Cody, Lieut. LOUIS S. WEAVER, York; from Camp Sevier, Capt. ARTHUR E. DAVIS, Scranton. With the board examining the troops for cardiovascular diseases, from Lakewood, Major EDWARD H. GOODMAN, Philadelphia.

To Camp Pike, Litle Rock, Ark., for duty, from Fort Oglethorpe, Lieut. ALBERT T. RANSOME, Philadelphia.

To Camp Sevier, Greenville, S. C., for temporary duty, from Army Medical School, Lieut. FRANCIS B. KING, Lansdowne.

To Camp Sherman, Chillicothe, Ohio base hospital, from Camp Jackson, Lieut. FRANCIS V. LAURENT, Pittsburgh. With the board examining the troops for cardiovascular diseases, from Fort Thomas, Ky., Capt. JOSEPH H. BARACH, Pittsburgh.

To Camp Wadsworth, Spartanburg, S. C., for duty, Lieuts. JOSEPH H. WATSON, Jeanette; MAJOR H. JOSEPH, Philadelphia; from Fort Oglethorpe, Capt. EDWARD L. DAVIS, Berwick; Lieut. HENRY N. SCHOLL, Kulpsville.

To Dover, N. J., for duty, from Williamsbridge, Lieut. JOHN J. KOLSKI, Donora.

To Fort Benjamin Harrison, with the board examining the troops for tuberculosis, from New Haven, Lieut. JULIUS H. GOLDSTEIN, Pittsburgh.

To Fort Clark, Texas, for duty, from Fort Oglethorpe, Lieut. BOYD W. SCHAFFNER, Ellwood.

To Fort McPherson, Ga., for duty, Capt. SAMUEL D. INGHAM, Huntington Valley.

To Fort Oglethorpe for instruction, Capts. LU VAN L. BROWN, Castle Shannon; GEORGE W. SMELTZ, Markleton; MADISON U. STONEMAN, Pittsburgh; Lieuts. HERBERT S. McKINSTRY, North Wales; JOSEPH V. BURNS, Coaldale; LOUIS J. LIVINGOOD, Philadelphia; RALPH J. ASKIN, SAMUEL H. KELLER, JOHN R. MORGAN, NORMAN O. OSCHSENHIRT, BYRON E. SHAW, Pittsburgh; ROY L. LANGDON, Willow Grove; from Camp A. A. Humphreys, Lieut. JULIUS A. BLASSER, Philadelphia; from Camp Meade, FRANCIS L. ALEXITIS, Wilkes-Barre; from Pittsburgh, Lieut. NICHOLAS G. L. SHILLITO.

To Fort Sam Houston, Texas, for duty, from Camp Sevier, Lieut. JOHN W. THOMPSON, Selinsgrove.

To Hoboken, N. J., for duty, from Fort Oglethorpe, Lieuts. ALEXANDER W. SPEARS, Grindstone; CHARLES H. WOLFE, Pittsburgh; from New York City, Major EVAN W. MEREDITH, Pittsburgh.

To Lakehurst, N. J., for duty, from Camp Leach, Lieut. MICHAEL M. WOLFE, Philadelphia.

To Lakewood, N. J., for duty, Lieuts. WILLIAM D. STROUD, Philadelphia; MORRIS FIRSHMAN, Pittsburgh; from Camp Gordon, Lieut. LESLIE N. GAY, Shamokin.

To Lonoke, Ark., Elberta Field, for duty, from Camp Jackson, Capt. HARRISON A. GREAVES, Philadelphia.

To New York City, Neurological Institute, for intensive training, Lieuts. HENRY B. MIKELBERY, ABRAHAM M. ORNSTEIN, Philadelphia.

To Pittsburgh, Pa., Carnegie Building, for instruction, and on completion *to Camp Sherman*, Chillicothe, Ohio, base hospital, Lieut. GORSHON GINSBURG, Philadelphia.

To report to the commanding general, Philippine Department, for duty, from Camp Shelby, Capt. WILLIAM RUOFF, Philadelphia.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion *to Camp Dodge*, Des Moines, Iowa, base hospital, from Fort Oglethorpe, Capt. HARRY A. SPANGLER, Carlisle.

To Rockefeller Institute for instruction, and on completion *to Fort Oglethorpe*, from New York City, Lieut. JOHN D. DONNELLY, Philadelphia. For instruction in laboratory work, from Camp Logan, Lieut. THEODORE MELNICK, Philadelphia. For instruction in the treatment of infected wounds, and on completion *to Camp Meade*, Annapolis Junction, Md., base hospital, Lieut. EDWARD S. DILLON, Philadelphia. On completion *to Walter Reed General Hospital* for temporary duty, Lieut. EDWIN R. HAGIN, Sharon.

To West Lafayette, Ind., Purdue University, to make physical examinations and give medical attention to the drafted men enrolled at this institution, and on completion *to his proper station*, from Fort Oglethorpe, Capt. HARRY BRADY, Masontown.

Honorably discharged on account of physical disability existing prior to entrance into the service, Lieut. ADOLPH H. FRIEDMAN, Philadelphia.

Porto Rico

To Camp Las Casas, San Juan, P. R., for duty, Capt. ALBERT G. MEHRHOF, Guayama; Lieut. LOUIS P. DAME, San Juan; from Camp Cody, Lieut. MANUEL DIAZ GARCIS, Barceloneta.

Rhode Island

To Fort Oglethorpe for instruction, Lieut. THOMAS S. FLYNN, Woonsocket.

To Rockefeller Institute for instruction in laboratory work, and on completion *to Army Medical School* for duty, Capt. WILLIAM G. DWINNELL, Providence.

The following order has been revoked: *To Cape May, N. J.*, base hospital, Lieut. FREDERICK N. BIGELOW, Providence.

South Carolina

To Camp Wadsworth, Spartanburg, S. C., for duty, Lieut. RALPH K. FOSTER, Timmonsville; from Fort Myer, Lieut. WILLIAM E. WHITESIDE, Greenville.

To Fort Oglethorpe for instruction, Lieut. JAMES E. DOUGLASS, Winnsboro.

South Dakota

To Boston, Mass., Harvard Graduate School of Medicine, for instruction, from Fort Riley, Lieut. LAWRENCE J. BROOKMAN, Vermilion.

To Camp Custer, Battle Creek, Mich., base hospital, from Milwaukee, Lieut. CARL N. HARRIS, Wilmot.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion *to Camp Grant*, Rockford, Ill., base hospital, Lieut. ARTHUR F. GROVE, Dell Rapids.

Tennessee

To Boston, Mass., Franklin Union Institute, for duty, from Fort Oglethorpe, Capt. THOMAS F. CHAMBERS, Cleveland.

To Camp Joseph E. Johnston, Jacksonville, Fla., for duty, from Fort Oglethorpe, Lieut. YOURA S. BROWN, Halls.

To Camp Lee, Petersburg, Va., for duty, Lieut. BENJAMIN J. COGDILL, Vestal; from Fort Oglethorpe, Lieut. JOHN H. HUFF, Sevierville.

To Camp Pike, Little Rock, Ark., with the board examining the command for cardiovascular diseases, Capt. OVAL N. BRYAN, Nashville.

To Camp Wadsworth, Spartanburg, S. C., for duty, Lieuts. LEROY S. McMULLEN, Knoxville; WALTER L. BOSWELL, Macon; from Fort Oglethorpe, Lieut. CHESTER A. SKELTON, St. Elmo.

To Fort Oglethorpe for instruction, Capt. JOHN J. McSWAIN, Paris; Lieuts. SPENCER B. McCLARY, Benton; GEORGE T. WILHEM, Memphis.

To Indianapolis, Ind., to give medical attention to drafted men, from Fort Oglethorpe, Lieut. WILLIAM T. BUCK, Henderson.

To Waynesville, N. C., for duty, from Camp Sevier, Lieut. JOHN O. WOODS, Newport.

Texas

To Boston, Mass., Harvard Graduate School of Medicine, for instruction, from Fort Oglethorpe, Capt. HOWARD R. DUDGEON, Waco.

To Camp Dix, Wrightstown, N. J., for duty, from Camp Logan, Capt. WALTER C. JOHNSON, Pharr; from Camp Travis, Capt. BERNARD F. SMITH, San Antonio.

To Camp Jackson, Columbia, S. C., base hospital, from San Antonio, Lieut. EDWARD B. JONES, Jacksonville.

To Camp Kearny, Linda Vista, Calif., base hospital, from Camp Logan, Capt. EUGENE R. CARPENTER, El Paso.

To Camp MacArthur, Waco, Texas, base hospital, Lieut. SCOTT C. APPLEWHITE, San Antonio.

To Camp Meade, Annapolis Junction, Md., for duty, from Camp Cody, Lieut. ERNEST HAMILTON, Kilgore.

To Camp Travis, Fort Sam Houston, Texas, base hospital, Lieuts. THOMAS C. BREWER, Dallas; CARROL L. MOORE, Houston. With the board examining the troops for cardiovascular diseases, Lieut. DAVID W. CARTER, Jr., Georgetown.

To Camp Wheeler, Macon, Ga., base hospital, from Camp Crane, Capt. GEORGE C. BRUNNELLE, El Paso.

To Fort Leavenworth, Kan., for duty, Capt. WILBUR F. THOMSON, Beaumont; Lieut. GEORGE C. KINDLEY, Dallas.

To Fort Oglethorpe for duty, from Fort McPherson, Lieut. CLARENCE R. MILLER, San Angelo. For instruction, Major FREDERICK O. WAAGE, El Paso; Capts. JASPER GRIMES, J. BOYD SWONGER, Beaumont; JAMES S. WHEELER, Coryell; JAMES P. GIBBS, Houston; Lieuts. OSCAR H. MAYO, Belton; JOHN W. MACUNE, Hillsboro; SIMM H. MOORE, HARRY K. MORRISON, EDWARD C. MURRAY, Houston; JOHN W. BLAKE, Rosenberg; WILLIAM S. HANSON, WILLIAM B. URMSTON, San Antonio.

To Fort Riley, base hospital, Lieut. ROGER A. THARP, Austin.

To Fort Sam Houston, Texas, base hospital, from Camp Bowie, Major JAMES G. FLYNN, Fort Crockett; from Camp Beauregard, Lieut. COLEMAN J. CARTER, Oakwoods.

To Montgomery, Ala., Signal Corps Aviation School, for duty, from Mineola, Capt. ROBERT A. TRUMBULL, Dallas.

To New York City, Bellevue Hospital, for instruction, and on completion *to Camp Meade*, Annapolis Junction, Md., base hospital, Major HERSCHEL F. CONNELLY, Waco.

Utah

To Boston, Mass., Harvard Graduate School of Medicine, for instruction, from Fort Riley, Lieut. CHARLES E. BRAIN, Salt Lake City.

To Fort Logan, Colo., for duty, from Fort H. G. Wright, Lieut. GEORGE W. CLARKE, Springville.

Vermont

To Camp Kearny, Linda Vista, Calif., with the board examining the command for nervous and mental diseases, from San Francisco, Capt. SIDNEY M. BUNKER, Burlington.

To Camp Lee, Petersburg, Va., for duty, from Fort Oglethorpe, Lieut. JAMES L. LOVEJOY, Manchester Depot. *To Fort McPherson, Ga.*, for duty, Lieut. HAROLD F. TAYLOR, Burlington.

To Fort Oglethorpe for instruction, Lieut. DAVID R. BROWN, Lindenwille.

To Indianapolis, Ind., to give medical attention to the drafted men, from Fort Oglethorpe, Capt. NICHOLAS DELEHANTY, Rutland.

Virginia

To Camp Jackson, Columbia, S. C., for duty, from Camp Zachary Taylor, Lieut. SAMUEL P. OAST, Portsmouth.

To Camp Lee, Petersburg, Va., base hospital, Lieut. MATHIAS GROVE-HAGEN, Richmond. For duty, from Fort Oglethorpe, Lieut. CLAY M. EASTER, Chincoteague Island.

To Camp MacArthur, Waco, Texas, with the board examining the command for nervous and mental diseases, from Camp Gordon, Lieut. JAMES A. MERIWETHER, Holcombs Rock.

To Camp Zachary Taylor, Louisville, Ky., for duty, from Camp Lee, Capt. HENRY S. STERN, Richmond.

To Fort Oglethorpe for instruction, Capt. HARRY WALL, Claremont; Lieut. WILLIAM I. LAUGHON, Richmond.

To Hoboken, N. J., for temporary duty, from Camp Meade, Lieut. ROBERT S. PRESTON, Richmond.

To Washington, D. C., for temporary duty in the Surgeon-General's Office, from Fort Oglethorpe, Capt. LEWIS M. ALLEN, Gaylord.

Washington

To Alcatraz, Calif., for duty, from Camp Fremont, Capt. FRANK H. COLLINS, Goldendale.

To Camp Lewis, American Lake, Wash., as a member of the board examining the command for tuberculosis, Lieut. CHARLES D. HUNTER, Tacoma.

To Fort Sam Houston, Texas, for duty, from Camp Sheridan, Lieut. WALTER A. BURG, Uniontown.

To Hoboken, N. J., base hospital, from Fort Lawton, Major CHARLES A. BETTS, Fort Lawton.

To Rock Island, Ill., for duty, from Fort Riley, Lieut. LEGRAND SPAULDING, Kennewick.

To San Francisco, Calif., for instruction, and on completion *to his proper station*, from Camp Lewis, Capt. HENRY H. SLATER, Deer Park.

West Virginia

To Boston, Mass., Harvard Graduate School of Medicine, for instruction, from Camp Pike, Capt. EMERSON MEGRALL, Wheeling.

To Camp Greene, N. C., Charlotte, base hospital, Lieut. CHARLES F. MAHOOD, Huntington; ROBERT J. WILKINSON, Huntington.

To Camp Lee, Petersburg, Va., base hospital, Lieut. ROBERT J. WILKINSON, Huntington. With the board examining the troops for tuberculosis, from Camp Sevier, Lieut. FERDINAND W. WIEHE, Wheeling.

To Camp Wadsworth, Spartanburg, S. C., for duty, from Fort Oglethorpe, Capt. WILLIAM C. COVEY, Pemberton.

To Fort Oglethorpe for instruction, Lieuts. ETLEY P. SMITH, Barrackville; CARTER S. FLEMING, CLAUDE M. VAUGHAN, Fairmont; JOHN H. HOSKINS, Lillybrook; LUSIUS LAMAR, Minnehaha Springs; from Army Medical School, Lieut. JOHN E. MILLER, Widen.

To Fort Porter, N. Y., for duty, Capt. CHARLES A. BARLOW, Beverley.

Wisconsin

To Camp Dix, Wrightstown, N. J., for duty, Lieut. JUSTUS SUTHERLAND, Brodhead.

To Camp Grant, Rockford, Ill., for duty, from Camp Logan, Capt. ALBERT G. JENER, Milwaukee.

To Camp Jackson, Columbia, S. C., for duty, Lieut. HENRY H. AINSWORTH, Madison; from Camp Dodge, Lieut. THOMAS C. CLARKE, Oconto.

To Camp Meade, Annapolis Junction, Md., for duty, from Camp Sherman, Lieut. WILLIAM N. MOORE, Appleton.

To Camp Pike, Little Rock, Ark., for duty, from Fort Riley, Capt. GEORGE W. FIELD, Janesville.

To Fort Oglethorpe for instruction, Lieuts. LEO. A. HOFFMAN, Campbellsport; RALPH B. QUINN, Darlington; LAUREL E. YOUMAN, Mukwonago; CHARLES C. DAVIN, New Richmond; DE WAYNE TOWNSEND, Oconomowoc; from Fort Myer, Lieut. CLARENCE N. SONNENBURG, Sheboygan.

To Lakewood, N. J., for temporary duty, Lieut. EUGENE A. GATTERDAM, La Crosse.

To report to the comanding general, Philippine Department, for duty, from Camp Cody, Capt. GEORGE A. BADING, Milwaukee.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion *to Camp Sheridan*, Montgomery, Ala., base hospital, Lieut. GEORGE M. SMITH, Chippewa Falls. On completion *to Camp Zachary Taylor*, Louisville, Ky., base hospital, Lieut. ANTHONY H. LOUZE, Brodhead.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion *to Camp Sevier*, Greenville, S. C., base hospital, Capt. THOMAS F. SHINNICK, Beloit.

Wyoming

To Camp Fremont, Palo Alto, Calif., as orthopedic surgeon, from Chicago, Lieut. ROBERT H. SANDERS, Kemmerer.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST; SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION, PUBLIC HEALTH, ETC.)

ILLINOIS

Service Flag Unfurled.—At the meeting of the Vermilion County Medical Society, at Danville, June 4, a service flag bearing seventeen stars was dedicated. The principal address was delivered by Dr. Elmer B. Cooley, Danville, formerly president of the Illinois State Medical Society.

Continuous Term for Medical School.—The University of Illinois College of Medicine, announces that, beginning June 3, it will be operated on the quadrimester system of three terms of four months each per calendar year. The courses will be so arranged that the students may enter the school at the beginning of any of the three terms.

Women's Club Election.—At the annual meeting of the Medical Women's Club, June 19, the following officers were elected: president, Dr. May Cushman Rice; vice presidents, Drs. Katherine B. Rich and Clara Jacobson; secretary, Dr. Grace H. Campbell; treasurer, Dr. Ione F. Beem, and editor of the *Bulletin*, Dr. Sadie Bay Adair, all of Chicago.

Chicago

Annual Meeting of Physicians' Club.—At the annual meeting of the Physicians' Club of Chicago the following officers were elected: chairman, A. A. O'Neill; secretary, V. D. Lespinasse; treasurer, H. W. Cheney; directors, E. J. Doering, D. N. Eisendrath, O. W. McMichael and A. M. Corwin. The closing function of the year was a banquet in honor of Major-General Gorgas, at which representatives of the various departments of the Army were speakers.

Extending Infant Welfare Work.—Four new infant welfare stations will be established in Chicago as the result of the money-raising campaign during the recent baby week, when $67,000 was raised, $2,000 more than the goal set. Heretofore, only children under 2 years have been cared for at the stations, but it is hoped that the resources will soon allow an extension of the work to include children under 6 years. There are now twenty-two infant welfare stations. The increase will make the number twenty-six.

INDIANA

Ground Broken for Medical School.—The first ground was broken for the new $238,000 building of the Indiana University School of Medicine, on the ground of the Robert W. Long Hospital, Indianapolis, June 17, by Governor Goodrich, who also made the principal address.

Personal.—Dr. Marcus Ravdin, Evansville, has presented Indiana University with a gold medal to be given annually to the student of the medical department who attains the greatest proficiency during his four years' course.—Dr. Herman G. Morgan, secretary of the Indianapolis Board of Health, has been appointed superintendent of the city hospital, succeeding Dr. Thomas L. Sullivan, who has entered military service.

MAINE

Personal.—Dr. Leverett D. Bristol, Augusta, commissioner of the state department of health, has been designated as chairman of the state committee of the American Society for the Control of Cancer.

New State Officers.—At the annual meeting of the Maine Medical Association held in Portland, June 4 to 6, the following officers were elected: president, Dr. George H. Coombs, Waldoboro; vice presidents, Drs. John Sturgis, Auburn, and Charles W. Bell, Strong; secretary-treasurer, Dr. Bertram L. Bryant, Bangor, and councilor delegates, Drs. John F. Thompson, Portland; Ernest V. Call, Lewiston; Byron F. Barker, Bath; Oliver W. Turner, Augusta; Walter N. Miner, Calais, and Charles H. Burgess, Bangor.

MARYLAND

Fifth Case of Infantile Paralysis.—The health department announced recently that a suspect under observation for the past week had developed a genuine case of infantile paralysis. The patient is a Polish infant, 2 years old, living near the waterfront in southeast Baltimore. The child has paralysis of the right shoulder and weakness in the right leg. It is a mild attack and the fifth case of the disease to be reported in the city this year.

Flag Raising at U. S. Army General Hospital No. 7.—A flag donated by the workmen engaged in the construction of the new buildings at the U. S. Army General Hospital No. 7, Evergreen, Baltimore, which is for the treatment and training of soldiers blinded in service, was raised during the past week on the observation tower commanding a view of the grounds. Capt. Francis E. Chuney, a member of the hospital staff, supervised the arrangements.

Personal.—Dr. C. Frank Jones, health warden of the fifteenth ward is convalescent after an operation performed at St. Joseph's Hospital a short time ago.——Mrs. Agnes C. Hartridge, formerly superintendent of nurses at University Hospital, Augusta, Ga., has been placed in charge of the admitting office at Johns Hopkins Hospital, succeeding Dr. William C. Leavenworth, who has been given supervision of the hospital dispensary. Dr. Leavenworth in his turn succeeded Dr. L. Palmer Holmes, New York City, who has entered military service.——Dr. Cornelius De Weese, Laurel, was acquitted, June 6, of criminal blame in connection with the death of Ambler McManus, Marlboro, who died as the result of injuries sustained when he was struck by an automobile driven by Dr. De Weese.——Dr. Edward P. Smith, for five years general superintendent of the Mercy Hospital, has resigned and will engage in practice in Baltimore.——The health department has appointed Dr. William Dew assistant supervisor of pasteurization in place of Dr. Claude van Bibber, resigned.——Dr. George A. Fleming, Baltimore, was exonerated by the coroner from all blame in the death of James B. Loane, who was struck by an automobile driven by Dr. Fleming and so severely injured that he died before reaching the Franklin Square Hospital.

MICHIGAN

New Society Officers.—At the annual meeting of the Wayne County Medical Society, held in Detroit, Dr. John L. Bell was elected president; Dr. Walter J. Wilson, Jr., vice president, and Dr. Raymond C. Andries, secretary.

Damages for Typhoid.—Damages amounting to $50,462 were granted to members of the Detroit Commandery, No. 1, K. T., and members of their families, on account of sickness caused by drinking polluted water from the Sault Ste. Marie River during a cruise on the steamship South American, in June, 1915.

Tuberculosis Farm for Detroit.—Dr. James W. Inches, health officer of Detroit, proposes to purchase a large tract of land suitable for farming and the erection of a large infirmary and a number of cottages for the treatment of cases of incipient tuberculosis. The proposed institution will cost about $1,000,000.

Personal.—Dr. Vinton J. Rickerd, Charlotte, is reported to be seriously ill with septicemia due to an infected wound of the finger.——Dr. Wayne J. Atwell, instructor in anatomy in the University of Michigan, Ann Arbor, has been appointed professor of anatomy in the University of Buffalo.——Dr. M. N. Nielson, Calumet, has been appointed oculist for the Middle Range Railroad.

To Study Sanatoriums.—Drs. Francis Duffield, Detroit; James W. Inches, St. Clair, and Albert M. Wehenkel of the Detroit Board of Health, and William B. Stratton have gone to Boston to attend the meeting of the National Tuberculosis Association and also to study sanatorium plans and investigate methods of handling the tuberculosis problem. For this work the Detroit City Council has made an appropriation of $2,000.

College Half a Century Old.—The Detroit College of Medicine and Surgery has completed fifty years of work and in celebration thereof, clinics were held, June 5 and 6, at the various hospitals in Detroit. Dr. John B. Deaver, Philadelphia, gave a surgical clinic at Harper Hospital, and Dr. Bertram W. Sippy, Chicago, a clinic on "Peptic Ulcer." On the evening of June 6, the annual smoker and vaudeville entertainment of the college was held.

MINNESOTA

War Chest for Hennepin County.—At a meeting of the Hennepin County Medical Society, May 27, seventy-five members of the society voted to contribute to a fund of at

least $35,000 a year, to be devoted to the uses of dependents of members of the society who have entered military service. Sixty members are at present in war service.

Personal.—Dr. Benjamin F. Simon has been appointed health commissioner of St. Paul, succeeding Dr. Justus O'Hage. ——Dr. G. M. Palmer, Bemidji, left for France, June 13, where he will do field work for the national Y. M. C. A.—— Dr. Andrew W. Hilger, St. Paul, was operated on, June 3, in St. Joseph's Hospital and is reported to be doing well.—— Dr. Charles H. Hunter, Minneapolis, is ill with nephritis at the Eitel Hospital, Minneapolis.——Dr. Pearl M. Hall, Minneapolis, has succeeded Dr. George W. Beach as superintendent of the Walker State Tuberculosis Sanatorium.——Dr. Albert J. Chesley, Minneapolis, has gone to France to assist in epidemiological work under the auspices of the American Red Cross.——Mr. Wallace G. Nye has been appointed permanent manager of the Minneapolis City Hospital.

MISSOURI

Personal.—Dr. Buford M. Colby, assistant physician at State Hospital No. 2, St. Joseph, has accepted the position of superintendent of the General Hospital at Kansas City.—— Dr. Paul E. Coil of Mexico has purchased a residence in that city, which will be remodeled and adapted to hospital uses. The plans call for accommodations for fourteen patients with modern equipment throughout. The hospital will be opened about July 15.

NEW YORK

State Health Officers Meet.—The annual conference of state health officers met in Saratoga, June 25, 26 and 27. Among the speakers were Surg.-Gen. William C. Gorgas, Miss Julia Lathrop, chief of the federal Children's Bureau; Col. Simon Flexner, Dr. Rufus I. Cole, Major Alexander Lambert, Dr. John A. Fordyce, Dr. Livingston Ferrand and Dr. S. Josephine Baker.

Personal.—Dr. Stephen A. Brown, Westfield, who was shot in the jaw by Joseph J. Johnson, was discharged recovered from the Brooks Memorial Hospital, June 12.——Dr. Ledra Heazlit, Auburn, was caught between his automobile and a doorway of his garage, June 9, fracturing his right hip.—— Dr. Roy H. Wixson has been appointed president; Dr. Harry C. Dumville, vice president, and Dr. George D. Stilson, secretary, of the Niagara Falls Academy of Medicine.

New York City

Conditions of Doctorate Degree.—Columbia University announces that after September of this year the degree of doctor of medicine will be conferred by the Columbia University College of Physicians and Surgeons only on men who have had one full year of service in a hospital under faculty supervision, in addition to four years in a medical school.

Personal.—Dr. Walter B. James, president of the New York Academy of Medicine, has been elected a trustee of Columbia University for a term of six years.——Dr. William H. Pierson, Brooklyn, has been elected president of the medical board of the Cumberland State Hospital.——Dr. Benjamin T. Terry, Brooklyn, has been appointed professor of pathology in Vanderbilt University, Nashville, Tenn., succeeding Dr. James W. Joblin, who has accepted an appointment at Columbia University.

Red Cross Money for Medical Research.—The war council of the American Red Cross announces that it has received a request from Cleveland H. Dodge, who subscribed $1,000,000 and various smaller amounts during the second Red Cross drive, that $250,000 of this sum be set aside for medical research work. In his letter to the American Red Cross, Mr. Dodge expresses himself as much impressed by the work done in ascertaining the methods of transmission of trench fever, and he directs that the foregoing sum be applied to a "thorough-going conduct of medical research designed to ascertain methods for the prevention and cure of diseases to which our soldiers and sailors may be exposed."

President Wilson Petitioned to Aid Hospitals.—A special meeting of the hospital conference of the city of New York met at the New York Hospital, June 17, to discuss ways and means of meeting the shortage of help of all kinds in the hospitals of this city and of the nation as a whole. Dr. Sigismund S. Goldwater brought out the fact that if the suggestion of a one-year intern course were adopted, on a basis of one intern to every twenty-five patients, there would be immediate need for 10,000 interns. Resolutions were adopted asking President Wilson to halt the further disruption of hospital organizations. A set of resolutions embodying a scheme to protect the hospitals and their personnel was drafted for presentation to Congress.

OHIO

New Venereal Disease Regulations.—New regulations regarding the control of venereal diseases in the state have been filed with the state department of health and will become effective, July 1. They require every case to be reported to the state board within twenty-four hours of diagnosis by physicians and dentists, with the name of the patient and various details, including the source of the infection, if possible. The patient is to be quarantined whenever the state commissioner of health considers quarantine necessary. Medical examination may be required of all persons "reasonably suspected of having venereal disease." This includes all prostitutes and persons associating with them. Cooperation of local health officials in the repression of prostitution is to be secured to the greatest possible extent.

PENNSYLVANIA

Personal.—While driving an automobile ambulance containing two convalescent soldiers into Philadelphia, Dr. Clifford B. Lull, West Scranton, attached to the Jefferson Ambulance Unit, rescued two women from an overturned and burning automobile.

Philadelphia

Class Banquet.—The fortieth anniversary banquet of the class of 1878, Medical Department of the University of Pennsylvania, was recently held at the University Club. Out of a graduating class of 128, there are 61 living.

Visit of British Medical Men.—The British medical deputation, touring this country to assist in the development of the Medical Reserve Corps, and consisting of Sir James Mackenzie, Sir William Arbuthnot Lane and Col. Herbert Bruce, were the guests of honor of the local medical societies at a reception in the ballroom of the Bellevue-Stratford Hotel, June 24.

Personal.—Dr. Elmer H. Funk has been appointed medical director of Jefferson Hospital Unit No. 28, which will soon leave for France.——Dr. Joseph Leidy has offered to be one of the 100 citizens to give $1,000 each to establish an endowment for the maintenance of military training in the high schools of the city.——Dr. Joseph S. Neff, Narberth, formerly director of health and charities, has been named by Governor Brumbaugh a member of the advisory board of the state department of health to succeed the late Senator Daniel Gerberich of Lebanon.

RHODE ISLAND

Personal.—Dr. A. J. Giggers, Providence, bacteriologist of the Rhode Island State Department of Health, has been appointed city bacteriologist of Rochester, N. Y.

State Society Meeting.—At the annual meeting of the Rhode Island Medical Society held in Providence, June 4 to 6, under the presidency of Dr. John Champlin, Westerly, the following officers were elected: president, Dr. Gardner T. Swarts, Providence; vice presidents, Drs. John M. Peters and Jesse E. Mowry; secretary, Dr. James W. Leech, Providence (reelected), and treasurer, Dr. Winthrop A. Risk.

UTAH

Appropriation for Social Disease Dispensary.—The city commission of Salt Lake City has voted an appropriation of $5,400 to defray the cost of the municipal dispensary to be established by the health department for the treatment of venereal diseases.

Personal.—Dr. Frank M. McHugh, Salt Lake City, suffered a severe scalp wound, and Dr. W. P. Skindale suffered contusions in a collision between a street car and an automobile in which they were riding, May 10.——Dr. Ephraim G. Hughes, Provo, has been appointed surgeon and consultant to the State Mental Hospital.

WASHINGTON

New County Officers.—At the annual meeting of the Lincoln County Medical Association, held in Harrington, June 2, Dr. Lee Ganson, Odessa, was elected president; Dr. Rufus

P. Moore, Davenport, vice president, and Dr. Joseph E. Bittner, Sprague, secretary-treasurer.

Medical Women Elect Officers.—At the annual meeting of the Medical Women's Club of Seattle, June 3, the following officers were elected: president, Dr. Sarah A. Kendall; vice president, Dr. Ada Collison; secretary, Dr. Mary D. Skinner, and treasurer, Dr. Mariette M. Armstrong.

Personal.—Dr. John R. Neely, Spokane, has been elected first assistant health officer, and Dr. David H. Ransom, Clarkston, second assistant city health officer of Spokane.——Dr. John W. Mowell, Olympia, chief medical adviser for the state of Washington, is ill with pneumonia at the base hospital at Camp Lewis.

WISCONSIN

Sanatorium Notes.—A fresh air camp for children suffering from tuberculosis has been opened near Neenah, with fifteen children in attendance.——The Jefferson County Board of Supervisors has appropriated $50,000 for a county tuberculosis sanatorium.

Personal.—Dr. William P. Barrett, Milwaukee, who was seriously injured in an automobile accident on the Cedarburg Road, June 9, is improving under treatment at the Emergency Hospital.——Dr. Gustave Windesheim has been reelected president, and Dr. George H. Ripley, vice chairman of the Kenosha Board of Health.

CANADA

Entire Class Volunteers.—At the convocation of the Western University, London, Ont., the entire graduating class in medicine appeared in uniform, as every member had volunteered to enter the Canadian Army Medical Corps for service at the front.

Medical Council Election.—At the concluding session of the medical council of Canada, held in Ottawa, June 12, it was decided that the next annual meeting should be held in Ottawa, on the third Tuesday in June, 1919. The following officers were elected: honorary president, Sir Thomas J. Roddick, Montreal (reelected); president, Dr. R. Eden Walker, New Westminster, B. C.; vice president, Dr. James C. Connell, Kingston, Ont.; registrar, Dr. Robert H. W. Powell, Ottawa, Ont. (reelected); general council, T. H. Chrysler, K. C., Ottawa, Ont.; auditor, G. L. Blatch, T. C. A., Ottawa, Ont.; executive committee, the honorary president, president and vice president, and Drs. Emmanuel P. Lachapelle, Montreal; Hon. Robert S. Thornton, Winnepeg, Manit.; Walter W. White, St. John's, N. B.; Hon. Reginald H. Brett, Edmonton, Alta., and Alexander MacNeill, Summerside, P. E. I.

Personal.—Dr. Charles J. C. O. Hastings, medical health officer of Toronto, delivered an address before the Alumni Association of the University of Buffalo, June 8, on "Influence of the War on Public Health Problems."——Lieut.-Col. William G. Anglin, Kingston, has been appointed registrar of man power in Kingston.——Dr. James D. Curtis, for two years medical officer for the workman's compensation board, Toronto, has returned to St. Catherine and has resumed practice.——Dr. Thomas E. Case, Dungannon, Ont., has been elected a member of the Ontario legislature by acclamation.——Lieut.-Col. Thomas M. Leask, C. A. M. C., Moose Jaw, Sask., has received the D. S. O.——Col. Herbert A. Bruce and Sir Arbuthnot Lane were given a dinner at the York Club, Toronto, the evening of Monday, June 17. Afterward, they addressed the members of the Toronto Academy of Medicine on war problems, especially on their mission to the United States. Sir James Mackenzie was unable to be present.——Lieut.-Col. Henry R. Casgrain, Windsor, Ont., is still in command of No. 8 Canadian Hospital at St. Cloud, France.——Dr. Helen MacMurchy, Toronto, has been elected president of the Women's Canadian Club, Toronto.——Col. Alexander Primrose, Toronto, is mentioned as professor of surgery in the University of Toronto, in case there should be a reorganization of the medical staff.——Lieut.-Col. George G. Nasmith, C. M. G., of the department of health, Toronto, has been presented with a diploma in public health by the University of Toronto.——Surg.-Gen. George A. Sterling Ryerson, Toronto, on his western trip to the Pacific Coast, was detained several weeks in Seattle by the serious illness of his wife.——Sir James A. Grant, Ottawa, is the only living member of the medical council of Ontario of 1866. He has been present at almost every meeting of the council in the last fifty-one years. He is also the only living member of the first Canadian Parliament at Confederation in 1867.——Dr. Alvin M. Warner, Vancouver, B. C., has been mentioned in dispatches from East Africa. Captain Warner gave up his practice early in 1916 to join the R. A. M. C. He was given command of the Blue Carrier Hospital and has built it up to an institution of 1,200 beds.

GENERAL

Surgeon-General Receives Degree.—Surg.-Gen. William C. Braisted, U. S. Navy, while in Chicago attending the meeting of the American Medical Association, had conferred on him the degree of Doctor of Science, by the Northwestern University, Evanston, Ill.

New Medico-Psychologic Officers.—At the annual meeting of the American Medico-Psychological Association in Chicago, June 5 to 7, under the presidency of James V. Anglin, St. Johns, N. B., the following officers were elected: president, Dr. Elmer E. Southard, Boston; vice president, Dr. Henry C. Eyman, Massillon, Ohio; secretary-treasurer, Dr. Arthur P. Herring, Baltimore, and auditor, Dr. Joseph C. Clark, Sykesville, Md.

Bequests and Donations.—The following bequests and donations have recently been announced:

Michael Reese Hospital, Chicago, $20,000, by the will of Joseph Schaffner.

Methodist Hospital and Deaconess Home, Indianapolis, $50,000, by the will of Charles W. Fairbanks, Indianapolis.

Medical Department, University of Pennsylvania, $50,000 for the founding of a chair of gynecology, by the will of Dr. William C. Goodell.

Middlebury (Conn.) College, $50,000 for the building of a hospital, a donation by Mr. William H. Porter, New York City.

Climatologists Elect Officers.—The American Climatological and Clinical Association, at its thirty-fifth annual convention held in Boston, June 5 to 6, elected the following officers: Dr. Guy Hinsdale, Hot Springs, Va., president; Drs. Joseph H. Pratt, Boston, and Hugh M. Kinghorn, Saranac Lake, N. Y., vice presidents; Dr. Arthur K. Stone, Boston, secretary-treasurer, and Dr. William D. Robinson, Philadelphia, recording secretary.

Surgeons Elect Officers.—At the annual meeting of the American Surgical Association, held in Cincinnati, June 6 to 8, under the presidency of Dr. Thomas W. Huntington, San Francisco, the following officers were elected: president, Dr. Lewis S. Pilcher, Brooklyn; vice presidents, Drs. George W. Crile and Edward Martin, Philadelphia; secretary, Dr. John H. Gibbon, Philadelphia; assistant secretary, Dr. Francis T. Stewart, Philadelphia; treasurer, Dr. Charles H. Peck, and assistant treasurer, Dr. Charles N. Dowd, New York City.

Federal Aid and Extension of Rural Sanitation.—At the sixteenth annual conference of state and territorial health authorities with the United States Public Health Service, Washington, D. C., June 3 and 4, resolutions were adopted reciting the need of rural sanitation and endorsing federal aid extension. The U. S. Public Health Service was urged to persist in securing legislation to this end, with the assistance of state health organizations. A federal system of supervision of the health of war industrial centers was advocated. Arkansas was commended for its compulsory vaccination law. The Chamberlain-Kahn bill for the suppression of venereal diseases among the civilian population, as well as in the military forces, was endorsed. A committee was recommended to study and report on sewage disposal in unsewered communities, and the authorities were called on to ascertain and make a statement of the number of members of the medical profession, sanitary engineers and graduate nurses taken from public health work by military needs, and the number that will probably be taken from such work. A committee of five was selected to confer with the committee on sanitary policy under war conditions.

FOREIGN

Prize for Research on Arsphenamin (Salvarsan).—The Academia de Ciencias Medicas of Bilbao, in northern Spain, offers two prizes of 250 pesetas each for the best work on arsphenamin and its derivatives, their production and chemical differentiation, and pharmacologic research on them and on methods of making them in Spain. Competition is open only to Spanish physicians, pharmacists, veterinarians and dentists, and the works must be in the hands of the secretary before Aug. 1, 1918. Address, Secretario general, C. Mendaza, Bilbao.

Netherlands Hospital Unit in France.—On the occasion of his leaving for return to the Netherlands, Dr. L. van den Steen, who has been at the head of the Netherlands ambulance at Pré Catalan, Paris, was presented with a bronze

medal by the Netherlands colony in Paris, with much ceremony. The French government also presented him with the Cross of the Legion of Honor in recognition of his devoted services for such a long time. The *palmes académiques* were also conferred on his wife. His place as chief of the ambulance has been taken by Dr. A. E. Vermey, who has been at the hospital since the first of the year.

Honors Asked for Medical Men in Austria.—The *Nederlandsch Tijdschrift* relates that in the lower house of the Austrian parliament an appeal recently was made to the authorities to arrange for more appropriate recognition of the difficult and dangerous work accomplished by the members of the medical corps of the army. Some of the deputies emphasized that many hundreds have died or been weakened by infectious diseases or have been held war prisoners for years. No provisions, however, have been made for decorating them for conspicuous gallantry beyond the same distinctions granted to nurses, officers' wives and court lackeys. The deputies demanded that the medical officers should be placed on the same plane in this respect as other military officers.

Medical Care for Refugees in France.—The *Progrès Médical* gives the text of a recent official notice which provides that army physicians and surgeons and the mobilized civilian medical men are to care for refugees in their respective districts when called on to do so by the prefect of the place when the local civilian force of physicians is inadequate to attend them. No fees are to be asked or accepted. Parties of refugees in barracks, improvised hospitals, etc., come under the provisions of this notice. The chief of the regional army medical department is to furnish the medical personnel at the request of the prefect. The medicines and dressings used are to be supplied by the usual provisions for care of the indigent. If they are provided by the army medical department, the latter will be reimbursed by the state department of the interior.

Death of Pozzi.—The cable brings the tragic news that Professor Pozzi of Paris, aged 72, was recently shot by a man—probably demented. Prof. Jean Samuel Pozzi was well known in this country, as he was a prominent figure at international medical gatherings, and what he had to say on gynecology and abdominal surgery was authoritative. He had been president of the Société de Chirurgie, d'Anthropologie and de Gynécologie, and presided at many medical congresses besides taking a prominent part in national legislation as senator, as member of the conseil de surveillance of the Assistance publique. He founded the *Revue de Gynécologie et de Chirurgie abdominale* in 1897, and his Traité de Gynécologie has been translated into five languages at least. Besides a love of travel, he was interested in archeology, and was vice president of the French society for archeologic research.

Deaths in the Profession Abroad.—**G. J. G. Minderop,** a prominent physician of Rotterdam, aged 84.—**B. Sommer,** professor of dermatology at the University of Buenos Aires; delegate from Argentina in various international medical and specialist gatherings; secretary of the international conference on leprosy at Berlin in 1897, and for a time chief of the Asistencia Publica of Buenos Aires and member of the city council.—**P. Gomes** of Bogota, Colombia, who helped to lay the foundation for the prophylaxis and treatment of epidemic diseases in Colombia, aged 74.—**J. G. del Castillo,** medical inspector of the Argentine navy into which he introduced vaccination against typhoid and obligatory prophylaxis against venereal disease.—**R. Frias,** professor of surgery at the University of Lisbon, aged 65.—**Perrin de la Touche,** professor of physiology at the medical school at Rennes and lately director of the school, also a son, grandson and great grandson of physicians.—The *Nederlandsch Tijdschrift* mentions the death of the surgeon, **F. Riedinger,** at Würzburg, aged 73; of the pediatrist **Ganghofner** of Prague, aged 75; of the neurologist **Lewandowsky** of Berlin, who succumbed to typhus, and of the ophthalmologist, **S. Bernheimer** of Innsbruck.

CORRECTION

Body of Colonel Reno Not Recovered.—Some time ago THE JOURNAL printed a statement to the effect that the body of Col. W. W. Reno, reported lost at sea, had been recovered. The statement was taken from a newspaper item. We find on investigation that the newspaper item was in error, and that, although thorough search has been made, the body of Colonel Reno has not been found.

LONDON LETTER

LONDON, May 28, 1918.

The Bombing of British Hospitals

German "thoroughness" has left no possible atrocity undone in this war, and attacks on the Red Cross by sea and land have become a commonplace. But for sheer fiendishness the recent bombing of a large group of hospitals in France may be regarded as the climax. The hospital tents cover a great area of ground, and the Germans are perfectly well aware of the character of the place; the entire absence of concealment makes it a mark which no airman could possibly miss. Bombs dropped from any height in any wind must land somewhere among the attendants' quarters or the tents occupied by the wounded. On a Sunday night two separate squadrons, numbering together more than a score of machines, dropped bombs which caused many casualties to patients, sisters and medical officers far exceeding those of a London raid. Taught by experience that the Red Cross is no protection against German barbarity, the authorities had provided shelters to which the sisters could have gone for refuge; but as the cots were filled with helpless wounded, many hundreds of whom could not be moved, they refused to leave their patients and did their best to keep up their courage. Many paid for their devotion with their lives. Some of the German machines came down low, and the raiders raked the hospital tents and attendants' quarters with their machine guns. The captain of one machine, formerly employed in the German diplomatic service, was brought down wounded. He tried at first to excuse himself by saying he saw no Red Cross. Challenged with the fact that he knew he was attacking hospitals he endeavored to plead that they should not be placed near railways and if they were they must take the consequences. But apart from the fact that hospitals must be near railways for the transport of patients, the raiders in this case did not attack the railway but deliberately bombed the hospital.

Physicians for the Army

New regulations have been made relating to applications for the exemption of physicians from army service. A special medical tribunal is to be appointed which can refer applications to local professional committees to report on them. As in the past, applications concerning members of the staffs of London hospitals will be referred to a special committee of reference. When the circumstances of each locality are under review, notification will be sent by the Minister of National Service to each physician affected, informing him of the time in which he may apply for exemption from military service. There is a special provision under which an exemption shall be subject to the condition that the physician shall undertake such professional service as the government may deem best in the national interests. This provision has been made because the demand for physicians for military and civil service is so great that only by a careful distribution of the available physicians can the requirements of the country be met.

An Index of Military Medical Officers

A card index of all medical officers whether regular, retired, special reserve, territorial, or holding temporary commissions, has been in existence for some time and is now being extended and completed. It has been found of great utility. Medical officers are asked to furnish particulars as to age, medical school, qualifications, hospital and other appointments, such as that of health officers, and to give information as to any special training, research work or publications. They also have to furnish information as to how they have been employed during the war. These particulars are transferred to index cards which are kept at the director general's office. When an officer is posted to an expeditionary force or command a duplicate is forwarded to the headquarters of the force where it may be added to, or form the basis of, what may be called a local card index. The blanks filled in by the medical officers after being used for the purpose of the card index will be passed on after classification to a series of specialist committees, who will grade the officers according to the extent and nature of their experience. Thus, for example, an officer who has undertaken or directed independent researches will be put in Grade 1, from which selection will be made for higher appointments, such as director of the military laboratory. An officer with less experience, who has shown himself capable of research under supervision, will be placed in Grade 2 and eligible

for similar employment in military laboratories. Officers trained in bacteriology, but who have not yet done research work, will be placed in Grade 3 and employed as assistants in military laboratories. The same principle will apply to other specialties.

A Hospital Alleged to Be a "Nuisance"

An unusual case has been heard in the High Court of Justice in which the proprietors of a house in Newport brought an action to restrain the defendants from using it as a hospital for surgical tuberculosis, on the grounds that this would be a "nuisance." One of the covenants in the lease was that no noisy, noisome or offensive trade or business was to be carried on. The plaintiffs alleged that tuberculosis is an infectious disease and the hospital a source of danger to the neighborhood. For the defendants a large mass of expert evidence was given that the hospital would not be a source of danger to the neighborhood and that there was no risk of infection to those in its immediate vicinity. The judge, Mr. Justice Eve, therefore decided that the hospital was not a nuisance. He found as to the sights that it was not proved that "every detail of the dressing of the patients was visible to inhabitants of neighboring houses." As to noise, it had been exaggerated, and, like the sights, could not reasonably be said to amount to anything that was noisome or offensive, though he could well understand that it might now and again be distressing and even annoying. As to smells, the case on the disinfectants, in his opinion, came to nothing, and as the alleged smell from the burning of dressings and bandages was not mentioned until the trial, when the defendants had no opportunity of investigating the matter, he should not allow that to be substituted for the complaint in the pleading. The hospital was in no sense a danger to the neighborhood and there was nothing in the way in which it was conducted that could properly be said to be noisome or offensive.

Precautions Against the Spread of Malaria in England

In a previous letter to THE JOURNAL some cases were related in which soldiers suffering from malaria had, through the medium of mosquitoes, been a source of infection. This danger from the return of infected soldiers from abroad has been apprehended by the War Office for some time. Early in 1917 it was decided to concentrate infected soldiers in eight special malaria hospitals under the control of medical officers experienced in the disease. Col. Sir Ronald Ross has now issued a memorandum on the subject. Indigenous cases of malaria began to appear in England last summer. The first series consisted of five or six cases of benign tertian in the Aldershot district among the troops. Then some civil and military cases were reported in other districts. Civilian health officers were communicated with and worked in conjunction with the military authorities. General instructions for the treatment of malaria patients, both in hospital and outside, were issued broadcast by the War Office. According to these, all malaria patients were given 60 grains of quinin weekly, and were provided with additional bottles of quinin tablets in order to prevent relapses of fever and the spread of the disease from malaria carriers to healthy persons. Simultaneously, all malaria patients in places where mosquitoes abounded were collected in sheds protected against the entry of the insects, when they were not sent to special malaria hospitals. The patients in the malaria hospitals were similarly protected when necessary. Much work was done in the way of clearing and oiling pools and watercourses. For military reasons it was not found possible altogether to keep old cases of malaria out of all districts where anophelines abound, but it is thought that protection from mosquitoe bites with persistent dosing with quinin will suffice to check the spread of malaria from the military cases in such localities. In Sir Ronald Ross' opinion the anophelines are comparatively so scarce in most parts of Britain as to render the danger of spread of malaria a negligible quantity, except only at a few spots where the insects are more numerous. Nevertheless special precautions are being taken even in places where no indigenous cases are known to have occurred. Several medical officers have been engaged in moving about among the most dangerous areas in order to supervise the measures that are being taken to inspect local conditions and to instruct local authorities, both civil and military. Sir Ronald Ross himself inspected most of the dangerous localities, and experienced entomologists have made surveys in them. A general system has been adopted for the immediate notification of all cases of malaria entering the United Kingdom from abroad, for the purpose of recording where such patients disembark and where they go when on leave or are stationed when on duty or in hospital. Health officers are informed when all such patients enter their districts, and the subsequent career of these persons is watched and a regular monthly report sent in by medical officers of all units and hospitals in the United Kingdom. These reports are collected and tabulated and studied. Up to the present no cases of indigenous malaria have been reported during the present year. Former foci of malaria in England are under minute supervision, and if new foci develop, experts will be sent to deal with the matter forthwith.

American Hospital in Ireland

A spacious dwelling house, with a large area of land attached, not far from Queenstown, has been acquired by the American naval authorities as a hospital for men in American naval vessels employed on this side of the Atlantic. Wooden dormitories to accommodate 250 sick men will be added to the present building. These dormitories will be built in America in sections and brought over to the hospital, which will be staffed by the American Red Cross.

PARIS LETTER

PARIS, May 23, 1918.

Tumors of Traumatic Origin

Prof. J. L. Faure recently directed attention to tumors of traumatic origin of which Dr. Vitrac of Libourne had reported two interesting cases. One of the patients was a soldier who had been wounded, April 3, 1917, by a large shell fragment which entered the external aspect of the thigh, below the great trochanter. The fragment was arrested in the popliteal region without having wounded any of the vessels or nerves. The projectile was extracted after a very free dissection, and the patient was later evacuated. April 29, much suppuration was present; but by the middle of June, cicatrization was complete. Toward the end of the month there was noted a swelling, about the size of a nut, very hard, but not painful or tender. Naturally, it was regarded as an inflammatory mass, but little by little it took on all the characteristics of a malignant tumor. Various treatments, including specific, were resorted to, but all met with failure. The tumor continued to increase in size until it measured 18 cm. in length and from 6 to 8 centimeters in width. It was extirpated, Sept. 21, 1917. The lower pole of the tumor was encapsulated, but the upper pole was separated with difficulty from the muscles, which were more or less degenerated and lardaceous. Recovery was uneventful. The enlarged glands in Scarpa's triangle reacted favorably to radiotherapy. Histologic examination of the tumor showed it to be an angiosarcoma.

The second case was that of a mounted artilleryman who, March 10, 1916, had his left thigh pressed severely against the trunk of a tree. He was in the hospital for a month, nothing more than the ordinary signs of a contusion being found as the result of his accident. He returned to duty and had no further inconvenience until September, 1917, when he noticed a mass on the antero-external surface of his thigh. This mass slowly increased in size and also became painful. The man was operated on, March 1, 1918. The tumor was firmly adherent to the surrounding tissues and extended down to the periosteum of the femur. It was removed with great difficulty, and much bleeding was present. The tumor was of about the size of an orange. Histologic examination showed that it was an encapsulated sarcoma with much telangiectasis.

These two observations seem to prove that a sarcomatous tumor, if the diagnosis was correct, may be caused by trauma. These cases occur too often for the fact to be doubted. Faure saw a woman recently who had received a severe blow on the breast in an automobile accident. The skin was severely contused and sloughed; a scar several centimeters square formed. Several months afterward an elongated movable mass was noted under the cicatrix with all the characteristics of a benign tumor. It has not been possible to determine its exact nature because the patient has refused operation; but today, three and a half years later, the tumor is still there and growing larger.

In the discussion that followed, Broca stated that there is no scientific proof of the traumatic origin of tumors, and that in all these cases the germ of the tumor had probably been present but dormant. Mauclaire said that a distinction must be made between malignant and benign tumors. A trauma is often the evident cause of an osteoma, but he did not believe that that was the case in the production of a

sarcoma. Kirmisson admitted that a trauma can, in some cases, act as a sort of stimulant or impulse to a latent neoplasm, which would not have taken on active growth except as the result of the accident. Thiéry said that in spite of the real importance of this subject, one can accept more easily the relationship of trauma with a number of other affections of unknown etiology (appendicitis, so-called local tuberculosis, tumor). Too little attention is paid, to begin with, to establishing the actual, distinct, important or probable occurrence of the trauma at the exact point where the neoplasm develops. More rigorous investigation would often show the unfoundedness of the patient's statements, even when there is no question of his sincerity. The tumor may not have developed on the precise spot that was traumatized. Thiéry does not know of a single case in which he has been able to establish even a probable relationship between the trauma and the appearance of the tumor (not including epithelial degenerations of cicatrices, of burns, etc). Chaput cited a case of trauma of the right iliac fossa by a wagon pole, which, in the course of a few weeks, was followed by the appearance of a sarcoma to which the patient, a young man, succumbed quickly. From the point of view of industrial accidents, responsibility is admitted when the occurrence of a severe trauma is established. Arrou saw a young girl who had received a trauma of the thigh, and in a few weeks a tumor, having all the appearances of a sarcoma, appeared. When that tumor was examined in the laboratory it was found to be merely an inflammatory mass.

National Headquarters for Rehabilitation of Crippled and Disabled Soldiers

The institution of this service was mentioned in a previous letter (THE JOURNAL, June 1, 1918, p. 1784). The members of the committee in charge of this work have been appointed for a period of three years. They consist of representatives of the ministry of work, of commerce, agriculture, marine, finance, public instruction and of the colonies. One of the representatives of the ministry of war is Dr. Jeanbrau, surgeon-major, of Montpellier, chief of the section of the professional reeducation of the disabled. Drs. Rieffel and Camus of Paris and several directors of the schools of reeducation are also members of the committee.

War Archives and Museum at Val-de-Grâce

Two years ago the undersecretary of state for the Service de Santé militaire ordered that the medical and surgical archives of the war be deposited in the Ecole d'application de médecine et de pharmacie militaire du Val-de-Grâce. This is situated on the rue Saint Jacques, Paris. Previously made collections and the libraries of the Ecole du Val-de-Grâce and other establishments constitute a most important educational aid, the further extension of which must be foreseen. In order to facilitate the growth and development of this institution, it has been decided to unite, in the form of autonomous establishments, the various services heretofore under the jurisdiction of the undersecretary of state of the Service de Santé militaire. The new establishment will be known as the musée du Val-de-Grâce, comprising the collection of the archives and documents of war, the central library of the Service de Santé militaire, and the archives of military medicine and pharmacy, so that all the services will be placed under the jurisdiction of the musée directors by order of the minister of war. The director of the Ecole d'application de médecine et de pharmacie militaire du Val-de-Grâce, will be *ex officio* in charge of the whole as the representative of the state war department.

Decoration of the Legion of Honor Awarded to Civilian Physicians for Devoted Services in War Time

The cross of the Legion of Honor (grade of officer) has been awarded to Dr. Langlet, mayor of Reims. Dr. Samsoen, municipal councilor of Hazebrouck, department du Nord, and Dr. Hoel of Reims have been made chevaliers of the Legion for herioc services rendered to the civilian population during the bombardments of Reims.

Promotions in the Auxiliary Medical Service

The undersecretary of state for the Service de Santé militaire has decreed that all physicians connected with the service auxiliaire, whether of the grade of médecin auxiliaire or not, shall be recommended for the grade of médecin aide-major of the second class, temporarily, if they have not yet made the request. These promotions will become effective automatically, provided the applicants have shown professional aptitude (*certificat de visite et de contre-visite* testifying to physical fitness for light medical service, for instance, in the hospitals of the *zone des étapes*), and that they will give the guarantees demanded of all officers.

Refugee Trains

One of the three societies composing the French Red Cross, the Société de secours aux blessés militaires, which has been administering to the needs of the reconstructed villages, has come to the assistance of the population of these villages when, on invasion by the enemy, they had to abandon their homes again. A service was organized at once to accompany the refugees on the transport trains. These trains which sometimes are in transit for day and night, are supplied with food by the nurses at the railroad depots where food is prepared in advance. Two nurses accompany each train until it reaches its destination. During the transit they give the occupants all the care which they need; they distribute milk to the children, give the sick warm drinks, soups and warm clothing. Each train is provided with a first aid box and a small pharmacy. Up to the first of May, thirty trips had already been made by sixty nurses of the society.

Personal

In its session of May 14, the Académie de médecine elected Dr. Theodore Tuffier a member of the section on surgical pathology, and Dr. Patein a member of the section on pharmacy. Dr. Patein is chief pharmacist of the Lariboisière hospital, and was formerly president of the Société de pharmacie and of the Société de thérapeutique.

Marriages

LIEUT. HAROLD LINHOFF BRERETON, M. R. C., U. S. Army, Emmettsburg Iowa, on duty at Camp Dix, N. J., to Miss Isabel Catherine Bayne of Fergus, Ont., formerly superintendent of nurses at the L. L. Culver, Union Hospital, Crawfordsville, Ind., at Brooklyn, N. Y., April 23.

ASST. SURG. CARL JAMES ROBERTSON, U. S. N. R. F., Litchfield, Minn., on duty at Great Lakes, Ill., to Miss Marjorie Kohl of Wayne, Nebraska, at Evanston, Ill., May 22.

LIEUT. LAWRENCE DAVID ENLOE, M. R. C., U. S. Army, Jefferson City, Mo.; on duty at Camp Pike, Ark., to Miss Dorothy Agee of Jefferson City, at St. Louis, June 4.

LIEUT. JOHN ANDREW SAARI, M. R. C., U. S. Army, Eveleth, Minn., on duty at Fort Lee, Va., to Miss Allie Miettenen of Brookston, Minn., in Chicago, June 1.

LIEUT. WALTER LELAND RICHARDS, M. C., U. S. Army, Pocomoke City, Md., on duty at Camp Greenleaf, Ga., to Miss Edith Coleman of Baltimore, June 8.

LIEUT. WILBUR CARTER, M. R. C., U. S. Army, Sherman, Texas, on duty at Fort Riley, Kan., to Miss Gladys Wolfe of Sherman Texas, April 8.

ASST. SURG. NOEL CARLYSLE ICE, U. S. P. H. S., of Cleveland, on duty at Nitro, W. Va., to Miss Zelma Jockisch of Beardstown, Ill., June 1.

CAPT. ROBERT ANTHONY KILDUFF, M. R. C., U. S. Army, Chester, Pa., on duty at Camp Meade, Md., to Miss Adelade Long, June 12.

LIEUT. CHARLES HENRY REINHARDT, M. R. C., U. S. Army, to Mrs. Mary Baker, both of Chicago, at Newport News, Va., April 13.

ASST. SURG. HARVEY ROSS MCALLISTER, U. S. Navy, Washington, D. C., to Miss Edith Lulu Sooy of Alameda, Calif., May 23.

P. A. SURG. FRANK HALDANE HAIGLER, U. S. Navy, Washington, D. C., to Miss Maybelle Hefferlin of Portland, Ore, June 11.

CAPT. HENRY EDWARD MELENEY, M. R. C., U. S. Army, Brooklyn, to Miss Elsie Genevra Todd of Springfield, Mass., June 12.

LIEUT. WALTER DARROW BAYARD, M. R. C., U. S. Army, Fargo, N. D., to Miss Myrtle Baker of Chicago, recently.

CHARLES CARTER CRANMER, New York City, to Miss Ada Hortense Van Giesen of Hackensack, N. J., June 27.

LIEUT. FRANK NEVIN OGDEN, M. R. C., U. S. Army, to Miss Ellen Price McCarty, both of Baltimore, June 13.

WILLIAM WARREN STEVENSON, Chicago, to Miss Caroline E. Pretzlaff, at Sibley, Ill., June 10.

Deaths

Major Eugene Wilson Caldwell, M. R. C., U. S. Army, New York City; University and Bellevue Hospital, Medical College, 1905; aged 44; a Fellow of the American Medical Association; a member of the American Roentgen Ray Association, and its president in 1907 to 1909; a member of the New York Academy of Medicine; who for more than twenty years had devoted his time almost exclusively to experimental work with the roentgen rays and their practical application in diagnosis; the inventor of the Caldwell liquid interrupter, and many other appliances used with the roentgen ray; visiting physician to the roentgen department of the Presbyterian Hospital, New York City; director of the Edward N. Gibbs Memorial X-Ray Laboratory, Bellevue Medical College; author of a standard textbook and of many monographs on the roentgen rays and telephony; died in Roosevelt Hospital, New York City, June 20, from burns sustained the day before while making roentgen-ray experiments.

Died in the Service
IN FRANCE
LIEUT. ABNER P. H. SAGE, M. R. C.,
U. S. ARMY, 1889-1918

Thomas Cook Stellwagen, Media, Pa.; University of Pennsylvania, Philadelphia, 1858; aged 76; a Fellow of the American Medical Association; a graduate of the Pennsylvania Dental College in 1861; and for nearly half a century a dentist of Philadelphia; for many years professor of physiology in the Philadelphia Dental College, and in the Medico-Chirurgical College of Philadelphia, and one of the founders of the latter institution; a veteran of the Civil War, in which he served in the Navy; died at his home, June 7.

Ernest Varian Scribner, Worcester, Mass.; Bowdoin Medical School, Brunswick and Portland, Me.; aged 62; a Fellow of the American Medical Association; a member of the American Medico-Psychological Association; for thirty-seven years a member of the staff of the Grafton and Worcester State hospitals, and assistant superintendent and superintendent of both institutions; an alienist of high rank; for six years superintendent of the Worcester State Hospital; died at his home, June 14.

George Edward Swift, Hudson, N. Y.; Albany (N. Y.) Medical College, 1884; aged 58; a member of the Medical Society of the State of New York; health officer of Hudson and Columbia County for several terms, and visiting physician to the Hudson Hospital; second lieutenant in the National Guard of the State of New York for five years; died in the Hudson Hospital, May 31, eleven days after an operation for appendicitis.

William Summer Clark, Los Angeles; Central College of Physicians and Surgeons, Indianapolis, 1881; aged 62; a Fellow of the American Medical Association; chairman of the tree-planting committee of the Los Angeles City Club, and prominent as a civic worker; was killed in an automobile accident near Compton, Calif., June 4.

Lieut. William Louis Miller, M. R. C., U. S. Army, Saginaw, Mich.; University of Oregon, Portland, 1915; aged 28; a Fellow of the American Medical Association; a registered pharmacist; on duty with Ambulance Company No. 128, Sanitary Train No. 107, Thirty-Second Division, American E. F. in France; was killed, May 28.

Valentine Mott, New York City; Bellevue Hospital Medical College, 1878; aged 65; a Fellow of the American Medical Association; attending surgeon, outdoor department, Bellevue Hospital; one of the earliest exponents of the Pasteur prophylactic treatment for hydrophobia; died in New York City, June 20, from angina pectoris.

James Livingston Wilgus, Chicago; Medical College of Indiana, Indianapolis, 1896; a Fellow of the American Medical Association; while driving in his automobile, over a level crossing near Grand Beach, Mich., was struck by a Michigan Central train, June 7, and died from his injuries a few hours later in a hospital at South Bend.

Charles Perkins Cook, Churchtown, N. Y.; New York Homeopathic Medical College, New York City, 1868; aged 73; for thirty years physician to the Hudson Orphan Asylum; for several years health officer of the city and once assistant surgeon-general of the state; died at the home of his son in Brookline, Mass., May 28.

Lieut. David Mays Vogt, M. R. C., U. S. Army, Newmanstown, Pa.; University of Pennsylvania, Philadelphia, aged 32; on duty at Picatinny Arsenal, Dover; was injured by the overturning of his automobile near Millburn, N. J., and died in the Overbrook Hospital, Summit, N. J., May 30, from his injuries.

Major Woods Walker Lynch, M. R. C., U. S. Army, Midland, Texas; University of Texas, Galveston, 1899; aged 45; on duty at Base Hospital, Camp Sheridan, Montgomery, Ala.; formerly a Fellow of the American Medical Association; a member of the State Medical Association of Texas; died, June 9.

William Vestus Balch, Galway, N. Y.; College of Physicians and Surgeons in the City of New York, 1871; aged 68; health officer of Saratoga County; vice president of the board of managers of the Homestead Sanatorium and the Saratoga County Tuberculosis Hospital; died at his home, June 5.

Michael Gramling Salley, Orangeburg, S. C.; University of Maryland, Baltimore, 1872; aged 68; formerly a Fellow of the American Medical Association; a member of the South Carolina Medical Association; died at the home of his daughter in Columbia, S. C., June 9, from angina pectoris.

Died in the Service
IN FRANCE
LIEUT. WILLIAM L. MILLER, M. R. C.,
U. S. ARMY, 1890-1918

Charles Herbert Williams, Boston; Harvard Medical School, 1874; aged 67; a Fellow of the American Medical Association, and a member of the American Ophthalmological Society; a well known specialist on diseases of the eye; died at his home in Cambridge, June 9, from heart disease.

Lieut. Abner Potts Hubert Sage, M. R. C., U. S. Army, Memphis, Tenn.; Jefferson Medical College, 1913; aged 29; a member of the Tennessee State Medical Association; on duty with a British field ambulance in France; died, May 30, from wounds received in action.

John William Harris, Eugene, Ore.; Willamette University, Salem, Ore., 1884; aged 64; formerly a member of the Oregon State Medical Association; was found dead, June 7, at Hendricks Park, near Eugene. His death is believed to have been due to exhaustion.

John Merritt, Brooklyn; Long Island College Hospital, Brooklyn, 1875; aged 72; for several years attending physician at the Sheltering Arms Day Nursery, Brooklyn; died at his home, March 9, from senile debility.

Orlando Benedict Mayer, Newberry, S. C.; Medical College of South Carolina, Charleston, 1874; aged 64; formerly a Fellow of the American Medical Association; died recently.

Henry R. Watts, Baltimore; University of Maryland, Baltimore, 1864; aged 75; a veteran of the Civil War, in which he served in the Navy; afterward appraiser in the Baltimore Custom House; for twenty years a pharmacist; died at his home, May 24.

Leo Joseph Flanagan, South San Francisco, Calif.; Georgetown University, Washington, D. C., 1911; aged 32; formerly a member of the Medical Society of the State of California; died in St. Mary's Hospital, San Francisco, June 11, from pneumonia.

Gilbert Emanuel Anderson, North Bend, Ore.; Barnes Medical College, St. Louis, 1911; aged 36; a member of the Oregon State Medical Association; died at his home, June 10, from septicemia, following an infected wound of the thumb.

Robert Graham Ralston, Cowansville, Pa.; Jefferson Medical College, 1860; aged 88; a member of the Medical Society of the State of Pennsylvania; for fifty-seven years a practitioner of Cowansville; died at his home, May 23.

Edwin G. Cowperthwaite, Philadelphia; Hahnemann Medical College, Philadelphia, 1895; aged 44; for several years a member of the staff of the eye dispensary of the Hahnemann Hospital, Philadelphia; died at his home, June 11.

Cleveland James Shambaugh, Cherry Valley, Ill.; Bennett Medical College, Chicago, 1911; aged 32; who was overcome by heat, June 16, committed suicide by cutting his throat in a garage in Cherry Valley, June 17.

Lieut. Charles Francis Butler, M. R. C., U. S. Army, Pittsburgh; Medico-Chirurgical College of Philadelphia, 1915; aged 23; a member of the Medical Society of the State of Pennsylvania; died, June 4.

Frederick Weygandt, Brooklyn; College of Physicians and Surgeons in the City of New York, 1875; aged 70; formerly a member of the Medical Society of the State of New York; died at his home, June 12.

Joseph J. Back, Newport, Ky.; Medical College of Ohio, Cincinnati, 1902; aged 39; formerly a member of the Kentucky State Medical Association; died at his home, June 9, from tuberculosis.

William S. Town, Rockford, N. Y.; University of Buffalo, N. Y., 1880; aged 64; health officer of Niagara County, and of the town of Cambria; died at the home of his brother in Newfane, June 8.

Adelaide Eliza Thomas, Florence, Mont.; State University of Iowa, College of Homeopathic Medicine, Iowa City, 1896; aged 77; died in Carleton, Mont.; June 10, from cerebral hemorrhage.

John Edwin Urehart, Ashfield, Mass.; University of Maryland, Baltimore, 1883; aged 58; a Fellow of the American Medical Association; died at his home, June 14, from cerebral hemorrhage.

Lewis Edward Harris, Danville, Va.; Medical College of Virginia, Richmond, 1867; aged 75; a member of the Medical Society of Virginia; a Confederate veteran; died at his home, recently.

Kenney M. Miller, Houston, Texas; University of Louisville, Ky., 1884; aged 58; a Fellow of the American Medical Association; died at his home, June 13, from heart disease.

Carl Louis Muller, Nevada City, Calif., Jefferson Medical College, 1883; aged 56; a Fellow of the American Medical Association; died in a hospital in San Francisco, June 11.

William C. Kelly, Flint, Mich.; Milwaukee (Wis.) Medical College, 1897; aged 61; a member of the Michigan State Medical Society; died at his home, June 8.

Donat F. Racicot, Biddeford, Me. (license, Maine, Act of 1895); aged 59; a practitioner for more than twenty-five years; died at his home, June 13.

Thomas Baxter Hopper, Jersey City, N. J.; Bellevue Hospital Medical College, 1891; aged 52; died at his home, April 8, from pneumonia.

Neal Baker Dean, Alexander City, Ala.; Tulane University, New Orleans, 1905; aged 34; died at his home, May 9, from bronchopneumonia.

Howell Cobb Davies, Youngstown, Ohio; University of Pittsburgh, 1897; aged 42; died at his home, June 9, from pernicious anemia.

Stephen W. Gerrow, New Paltz, N. Y., Castleton (Vt.) Medical College, 1882; aged 83; died at his home, June 13.

James Roderick Berwick, Methuen, Mass.; Dartmouth Medical School, Hanover, N. H., 1899; died suddenly, June 1.

A. N. Snoddy, Dayton, Ind.; Medical College of Ohio, Cincinnati, 1859; aged 84; died at his home, June 12.

Correspondence

UNRIGHTEOUS PROFITS IN PATENTED PRODUCTS

To the Editor:—In line with Dr. Bevan's address in regard to leaving German scientists and preparations alone and using American, I will state that "Aspirin Bayer" decreased in price from $8.80 to $4.40 per thousand at the time their patent expired, about eighteen months ago. The foregoing were prices I paid at that time, being a retail druggist. Physicians, not druggists, paid more. They were charging $4.40 per thousand above legitimate profit or they would not have reduced the price that amount when their protection expired. I wonder how many millions of these $4.40 went to help the kaiser.

The government should protect a patentee (if not a Hun) but should not allow him to collect cost plus a legitimate profit and then double the charge.

C. H. HARRIS, M.D., New Paris, Ohio.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

SERVICE FLAG—SALUTING THE COLORS

To the Editor:—1. Is the service flag intended for the Army and Navy service and their branches, the fighting men and the necessary men connected with each service aside from the fighting men, or does it also include Red Cross nurses? 2. Can you give me any information relative to the method of saluting the colors and of responding to the national air?

M. BACHMAN, M.D., Lake Park, Iowa.

ANSWER.—1. The service flag is displayed for those in the active service of the Army or the Navy of the country; Red Cross nurses on active duty with the fighting forces should be included.

2. Existing regulations governing the Army provide that when officers and enlisted men pass the national flag they will render homage as follows: If in civilian dress and covered, they will uncover, holding their head-dress opposite their left shoulder with their right hand; if uncovered, they will salute with the right-hand salute. Whenever the national air is played at any place where persons belonging to the military or naval service are present, all officers and enlisted men not in formation are required to stand at attention, facing toward the music, except when the flag is being lowered at sunset, on which occasion they are required to face toward the flag. If in civilian dress and uncovered, they should stand and salute at the first note of the air, retaining the position of salute until the last note of the air is played. If in civilian dress and covered, they are required to stand and uncover at the first note of the air, holding the head-dress opposite the left shoulder until the last note is played. In inclement weather only the head-dress may be held slightly raised. There are no laws on this subject governing the conduct of civilians, but unwritten law and excellent custom suggest that civilians act with equal courtesy toward the national colors and anthem.

THE THOMPSON MALTED FOOD STOCK PLAN

To the Editor:—About the middle of March a good many medical men here were induced to buy stock in Thompson's Malted Milk Co. of Waukesha, Wis. I bought to the amount of $45 cash. Others bought more and some less—the stock certificate sent me was for thirty shares at $1.50 per share.

The party who sold the stock was in town for at least two days. He told me that he was just out of New Orleans and had sold every doctor (not surgeons) of prominence in the place, gave the names and amount of stock taken and claimed that he had remained there while letters, etc., as to his reliability and that of the T. M. M. Co. was investigated. Said that he had cheerfully invited this investigation, etc.; said the Mayos used the malted milk exclusively in their hospital in Rochester; that the U. S. government had a big order for all the product they could get and preferred it to Horlick's or any other milk. Said that

as soon as the doctors, who were preferred, bought stock it would be offered to the drug stores. None was offered to any here I am told.

I told him I did not like the scheme as it did not look all right to me, but that I'd take a few shares, but wanted to know just what the stock was going to pay—I couldn't pin him down to exact figures, but he said I could not possibly lose and would have a nice little side-line that would come in very handy as the company had no debts and had paid for its plant and was selling stock in this manner, interesting doctors instead of advertising in the medical journals. By doctor's owning stock they would recommend this milk as it was the best and purest anyway. He never did say just how much the stock would pay, but said that there was no possible way for an investor to lose any money.

Do you know anything about this company? The man who sold us the stock said that it would be in every drug store here right away. I haven't yet seen any.

R. L. Randolph, M.D., Alexandria, La.

Answer.—Seven years ago physicians were told of the glowing prospects that might follow an investment in the Thompson's Malted Food concern; we have yet to hear of any dividends being paid. The Thompson Malted Food Company was discussed in the Propaganda Department, Oct. 24, 1914; it was again discussed in the Correspondence Department, April 28, 1917. A reprint of both these articles will be sent on receipt of a two-cent stamp.

THE BABINSKI TEST

To the Editor:—1. Who is, or was, Babinski? 2. What is the Babinski test?

Henry Ketcham, Dallas, S. D.

Answer.—1. Joseph François Felix Babinski was born, Nov. 17, 1857, of Polish parents. He was graduated in medicine in 1885, and in 1890 was appointed physician to the Hôpitaux de Paris. He is noted for his original studies on the subject of brain diseases and the diagnosis and treatment of vertigo. He is a French neurologist and is living at the present time.

2. The Babinski phenomenon consists of a stimulation of the sole of the foot producing extension of the hallux (great toe) instead of flexion. The normal plantar reflex is one of flexion of the great toe, while Babinski's plantar reflex is one of extension. Sometimes, in testing for Babinski's sign, in addition to extension of the hallux, a fanlike spreading out of the toes is observed—*phénomène d'éventail*. The presence of the reflex indicates a disordered and usually degenerated condition involving the pyramidal tract. It is, therefore, of value in differentiating between functional and organic nervous diseases.

COMMUTATION AND INSURANCE IN NAVY AS WELL AS IN ARMY

To the Editor:—1. Do officers in the Navy receive commutation the same as officers in the Army? 2. Are Naval officers allowed to carry government insurance at the same rate, etc., as officers in the Army? 3. Where do I report for examination? Please omit my name.

A. R. W.

Answer.—1. Yes.

2. Yes.

3. You may write to the Office of the Surgeon-General of the Navy, or to The Journal office, requesting an application blank, which may be forwarded to the Surgeon-General of the Navy accompanied by a request for examination before the nearest examiner.

PHYSICIANS INVITED TO CONTRIBUTE INFORMATION ON HAY-FEVER RESORTS

To the Editor:—In order to furnish reliable information to the large number of inquirers, we are preparing a list of places in various parts of the country where hay-fever subjects may find temporary relief. Physicians are therefore requested to assist in this work by sending a list of places, in their state, having the reputation of being free—or relatively free—of hay-fever.

The United States Department of Agriculture and the members of our botanical department are preparing a list of localities in relation to hay-fever from a botanic standpoint, but the report of physicians on this subject will aid greatly in establishing, for the benefit of the medical profession and the public generally, definite information on this subject.

William Scheppegrell, M.D., Audubon Building, New Orleans, President, American Hay-Fever Prevention Association.

To Arrest Paroxysmal Tachycardia.—According to a German writer, cited by *Hospitalstidende*, tickling the palate and throat, until vomiting is induced, will arrest an attack of paroxysmal tachycardia.

Medical Education and State Boards of Registration

COMING EXAMINATIONS

Alabama: Montgomery, July 9. Chairman, Dr. S. W. Welch, State Capitol, Montgomery.

Arizona: Phoenix, July 2. Sec., Dr. Allen H. Williams, 219 Goodrich Bldg., Phoenix.

Colorado: Denver, July 2. Sec., Dr. D. A. Strickler, 612 Empire Bldg., Denver.

Connecticut: New Haven, July 9-10. Sec. Regular Bd., Dr. Chas. A. Tuttle, 196 York St., New Haven; Sec. Eclectic Bd., Dr. J. E. Hair, 728 State St., Bridgeport; Sec. Homeo. Bd., Dr. E. C. M. Hall, 82 Grand Ave., New Haven.

District of Columbia: Washington, July 9-11. Sec., Dr. E. P. Copeland, The Rockingham, Washington.

Maine: Augusta, July 2-3. Sec., Dr. Frank N. Searle, 776 Congress St., Portland.

Massachusetts: Boston, July 9-11. Sec., Dr. W. P. Bowers, Rm. 501-1 Beacon St., Boston.

North Dakota: Grand Forks, July 2. Sec., Dr. G. M. Williamson, Grand Forks.

Oklahoma: Oklahoma City, July 9-10. Sec., Dr. J. J. Williams, Weatherford, Okla.

Oregon: Portland, July 2. Sec., Dr. Herbert S. Nichols, 802 Corbett Bldg., Portland.

Pennsylvania: Philadelphia and Pittsburgh, July 9-13. Sec., Mr. N. C. Schaeffer, State Capitol, Harrisburg.

Rhode Island: Providence, July 11. Sec., Dr. B. U. Richards, State House, Providence.

South Dakota: Deadwood, July 9. Sec., Dr. P. B. Jenkins, Wauhay.

Utah: Salt Lake City, July 1-2. Sec., Dr. G. F. Harding, 407 Templeton Bldg., Salt Lake City.

Washington: Tacoma, July 2. Sec., Dr. C. N. Suttner, 415 Old Nat'l Bldg., Spokane.

West Virginia: Wheeling, July 9. Health Com., Dr. S. L. Jepson, Masonic Bldg., Charleston.

New York March Examination

Mr. George M. Wiley, director, Examinations and Inspections Division, reports the written examination held at New York, March, 1918. The examination covered 8 subjects and included 80 questions. An average of 75 per cent. was required to pass. Of the 123 candidates examined, 115 passed and 8 failed. The following colleges were represented:

College	Passed	Year Grad.	Total No. Licensed
Harvard University		(1918)	2
Columbia University		(1918)	40
Fordham University		(1918)	40
New York Homeo. Med. Coll. and Flower Hosp.		(1918)	4
University and Bellevue Hosp. Med. College		(1918)	29
	Failed		
Columbia University		(1918)	3
Fordham University		(1918)	3
New York Homeo. Med. Coll. and Flower Hosp.		(1918)	1
University and Bellevue Hosp. Med. College		(1918)	1

Nevada May Examination

Dr. S. L. Lee, secretary of the Nevada State Board of Medical Examiners, reports the written examination held at Carson City, May 6-8, 1918. The examination covered 13 subjects and included 100 questions. An average of 75 per cent. was required to pass. One candidate was examined, who passed. Five candidates were licensed through reciprocity. The following colleges were represented:

College	Passed	Year Grad.	Per Cent.
Rush Medical College		(1913)	93.4

College	Licensed through reciprocity	Year Grad.	Reciprocity with
Georgia College of Eclec. Med. and Surg.		(1899)	Texas
Rush Medical College		(1903)	Illinois
Barnes Medical College		(1893)	Missouri
Dartmouth Medical School		(1899)	Maine
Temple University		(1914)	Penna.

Iowa Reciprocity Report

Dr. G. H. Sumner, secretary of the Iowa State Board of Medical Examiners, reports that 12 candidates were licensed through reciprocity at the meeting held May 1, 1918. The following colleges were represented:

College	Licensed through reciprocity	Year Grad.	Reciprocity with
Bennett Medical College		(1914)	Illinois
Chicago College of Med. and Surg.	(1909) Illinois;	(1915)	Nebraska
Chicago Medical College		(1877)	Wisconsin

Hering Medical College	(1907)	Illinois
National Medical University	(1902)	New Mexico
Northwestern University	(1914)	Illinois
Maryland Medical College	(1912)	New Hamp.
John A. Creighton Medical College	(1915) (1917)	Nebraska
Ohio Medical University	(1907)	Ohio
Jefferson Medical College	(1916)	Wisconsin

Medicolegal

Liability of Company and Physician Under Contract for Medical Services

(Sloss-Sheffield Steel & Iron Co. et al. v. Taylor (Ala.), 77 So. R. 79)

The Court of Appeals of Alabama affirms a judgment for $300 damages in favor of the plaintiff, Mrs. Taylor, and against the defendants, the company and the "company doctor," who were sued jointly of alleged failure to render medical services to the plaintiff. The court says that it appeared that the company deducted 75 cents each month from the wages of its unmarried employees, and $1 each month from the wages of its married employees, and in consideration of this amount the company obligated itself, in the case of a married man, to render, in case of illness, medical services to him, his wife, and family. The "company doctor" was employed by the company to render medical services to its employees, and their wives and families, under this agreement. February 9, the company deducted $1 from the wages of the plaintiff's husband, 90 cents being paid to the physician, and 10 cents being retained by the company. March 5, the plaintiff was taken ill, and the physician was repeatedly requested, on the 5th, 6th and 7th, to visit her, but each time refused to do so, though, acting on Mr. Taylor's statement of the nature of his wife's malady, he furnished some medicine or phenolated petrolatum and codein tablets to Mr. Taylor to be administered to his wife, stating that it was unnecessary to make a professional call. On the evening of the 7th, Mr. Taylor called in another physician. It developed that Mrs. Taylor was suffering from an abscess, and by the 10th, when the defendant physician did call on her, had so far recovered as not to be in need of the services of a physician, the abscess having burst. The defendant admitted having told Mrs. Taylor's sister that he would treat Mrs. Taylor if she would take her to her house; that he would not go to Mr. Taylor's house to see her; that he did not want to have anything to do with a man that would take a case away from him and take another physician without consulting him. This was before March 9.

The court holds that the husband was under a legal duty to provide medical services and attention for his wife, when needed, so far as his ability would permit; and his contract with the defendant to render such services to her was a contract for her benefit, and the breach of it gave her the right to maintain an action therefor in her own name, either for the breach of the contract or for the negligent failure, if such there was, to perform the duty arising out of the agreement. After the defendants had entered into the agreement, it was not permissible for them to refuse to perform their part thereof, because the husband exercised his right to call in another physician. The husband was under no duty to notify the company doctor that he would call in another physician, and he was under no duty to employ only such physician as was acceptable to the professional taste of the company doctor. When the defendants entered into a valid contract to render professional services to Mrs. Taylor up to March 9, as the evidence tended to show they did, the law required them to perform their contract, and render such professional services as might be required of them up to that time, and their nonperformance could not be excused because other professional skill was obtained without their consent, unless it appeared that the additional physician materially interfered with the defendants in the discharge of their duty. It was urged that there could be no recovery in this case because a contract made by a husband for medical services to his wife is a contract made for the benefit of the husband, since he is under a legal duty to provide medical services for his wife in case of illness, and therefore the wife is only incidentally benefited by such a contract. But the fact that the husband was under such legal duty was one reason why the wife was entitled to maintain this action in her own name. The contract had for its purpose the preservation of the wife's life and health by placing at her disposal the professional skill and services of the company doctor. The benefit to her was direct and substantial. This court would find it difficult to hold otherwise, and at the same time maintain its self-respect.

The court cannot say that the damages awarded were excessive.

Value of Services Is Question for Jury

(Young v. Lichtenberg (N. Y.), 168 N. Y. Supp. 616)

The Supreme Court of New York, Appellate Term, First Department, which reverses a judgment obtained by the plaintiff, a physician, says that he brought this action against the defendant for the value of medical services rendered to the defendant at his request. The plaintiff testified at the trial as to his services and as to their reasonable value. His testimony was not contradicted. At the close of the testimony the defendant moved to dismiss the complaint, and his motion was denied. The plaintiff thereupon moved for the direction of a verdict, and the court directed one in his favor for $157, the amount demanded in the complaint and which the plaintiff had testified was the reasonable value of the services rendered. Thereafter the defendant asked to go to the jury on the question of fact involved in the determination of the value of the services. This motion was denied. The defendant's request to go to the jury on the question of fact was not made too late, and the only serious question presented by this appeal was whether, in view of the fact that the plaintiff's testimony as to the value of his services was uncontradicted, there was any question of fact that the jury could determine. It was conceded that, in actions brought by attorneys for the value of professional services, the jury must assess the value of such services, even when there is no contradiction of the testimony adduced by the plaintiff as to the value of his services. Even though no case was cited in which the same rule has been announced by any court of this state in regard to services rendered by a physician, this court can see no possible distinction in principle as to the conclusiveness of expert opinion in regard to the value of professional services, in actions brought to recover for services rendered as an attorney and in actions brought to recover for services rendered as a physician. It follows that the judgment for the plaintiff should be reversed, and a new trial ordered, with $30 costs to the defendant to abide the event.

"Surgeon Not Liable for Sponges Being Left in Patient" —Standard of Diligence

(Cassingham v. Berry (Okla.), 168 Pac. R. 1070)

The Supreme Court of Oklahoma was reported in the Medicolegal Department of THE JOURNAL, Sept. 4, 1915, under the quoted heading, as having, in *Cassingham et al.* v. *Berry*, affirmed a judgment in favor of the defendant, and denied a rehearing, the action being one against a surgeon for having, as was alleged, negligently left gauze sponges in the body of the plaintiffs' mother, on whom the defendant had operated for the removal of the ovaries, which alleged negligence, it was charged, resulted in the death of the patient.

Now, on a rehearing, the court says that the one question involved in this case on which it has had misgivings was the doctrine that the degree of diligence that the law imposes on the surgeon is reasonable or ordinary care. The court earnestly requested and hoped that counsel in the argument on rehearing would give the court light on this question. But counsel did not cite, nor has the court been able to find, an instance in which the courts of law impose any standard of diligence on any one, other than reasonable and ordinary care. It is true this is a relative term. What would be reasonable and ordinary care under some conditions would be negligence under others. The importance, delicacy, hazard and moment of the undertaking all enter into the question as to what, under the circumstances, amounts to reasonable and ordinary care, and is a question of fact for the jury.

In the case at bar the evidence was that the defendant before beginning the operation counted the sponges to a trained nurse, who had been furnished by the husband of the patient, and repeatedly admonished her to keep an accurate count of the number of sponges inserted into the cavity, and did all he could to impress on her the importance of her accurately counting the number of sponges taken from the cavity, to insure that none that had been inserted remained in the cavity, and that, before closing the cavity, he asked the nurse if she had counted the sponges, and if all that had been inserted had been taken out of the cavity, and she assured him that she had counted them, and that they had all been taken out. It was also in evidence that this was an approved method, used by many leading surgeons, of keeping track of the number of sponges used in an abdominal operation.

And, under the law on diligence and the facts in this case, the court adheres to the opinion originally filed. All the justices concur.

The syllabus by the court says: The law imposes but one standard of diligence, and that is reasonable and ordinary care. This, however, is a relative term; and what would be reasonable and ordinary care under some conditions would amount to negligence under others. The importance, delicacy, hazard and moment of the undertaking all enter into the question as to what, under the circumstances, amounts to reasonable and ordinary care.

Remedy Where Board Revokes Certificate

(Knoop v. State Board of Health (R. I.), 102 Atl. R. 609)

The Supreme Court of Rhode Island dismisses a writ of certiorari—a writ to call up records or for review that was issued on a petition therefor. The court says the writ was sought for the purpose of quashing a record setting out the action of the members of the state board of health, whereby the certificate authorizing the petitioner to practice medicine and surgery in that state was revoked on the finding of the board that the petitioner had been guilty of gross unprofessional conduct and conduct making him an unfit person to practice medicine in the state. From the allegations of the petition it appeared, among other things, that the board served notice on him to appear before it on a certain date, and show cause why his certificate should not be revoked, and on or about said date gave him a bill of particulars in which it was alleged that he had been dispensing and distributing narcotic drugs in violation of the Harrison act, and in the United States District Court for the District of Rhode Island he had pleaded nolo contendre (I do not wish to contend) to an indictment found against him for violation of said act, and thereupon had been sentenced to pay a fine of $100; also that he had violated the provisions of the state statute by illegally prescribing various narcotic drugs, etc. In his brief the petitioner stated that he brought his petition for a writ of certiorari solely because the remedy which was open to him by way of appeal was utterly inadequate, because not only would he have to bear the burden of the cost of an appeal, but he must be without compensation and redress for what he styled the wrongful and summary procedure of the state board of health, and that his situation presented just such a case of unusual hardship as should appeal to the discretionary powers of this court for relief by certiorari.

Assuming, simply for the purpose of this discussion, that the contention of the petitioner was sound that the record of the indictment above referred to was not proper or adequate evidence to support the decision of the board, this court is of the opinion that the appropriate remedy of the petitioner was by appeal, and that no such exceptional case of hardship was presented as to warrant a review of the proceedings by certiorari. From the transcript of the testimony taken in the proceedings before the board of health, which was used by the parties to the hearing before this court on the motion and petition, it appeared that there was other evidence in addition to the record of the indictment produced before the board. It was true that the board apparently based its decision on the record of the plea of nolo contendere and sentence thereon; nevertheless there was other evidence presented to the board which was relevant to the issue, and in proceedings under the statute the remedy provided by appeal was simple and adequate; and this court cannot review by certiorari the question as to the adequacy of the evidence.

As the appeal vacates the proceedings before the board, so far as results go, the case on such appeal comes before this court for a trial on the merits of the case de novo (anew), and the fact that such trial may impose some additional expense on the petitioner does not differentiate this case from the ordinary case in which appeal is taken from the decision of an inferior tribunal which is claimed to be erroneous.

Society Proceedings

COMING MEETINGS

American Academy of Ophth. and Oto-Laryn., Denver, Aug. 6-8.
American Ophthalmological Society, New London, Conn., July 9-10.
Idaho State Medical Association, Seattle, July 17-19.
Montana Medical Association, Butte, July 10-11.
Washington State Medical Association, July 10.
Wyoming State Medical Society, Casper, Aug. 7.

MEDICAL SOCIETY OF THE STATE OF NEW YORK

One Hundred and Twelfth Annual Meeting, held at Albany, May 21-23, 1918

(Concluded from page 1977)

Etiology of Nephritis

DR. CHARLES JACK HUNT, Clifton Springs: A group of nephritics, without other etiologic factor than bacterial toxins that formed chronic foci, were studied by recognized renal functional tests under control diet both before and after removal of discoverable foci. Culture study revealed the *Streptococcus mucosus* as the principal pathogenic organism. Other bacterial forms, in the order of frequency, were a diphtheroid organism, *Bacillus mitis, Streptococcus candidus, Streptococcus viridans,* and the pneumococcus.

DISCUSSION

DR. CHARLES G. STOCKTON, Buffalo: These cases are due primarily either to infection alone or to a mixture of infection and metabolic defect. I have seen rather acute types of nephritis, with marked metabolic disturbances following infection, the infection producing anasarca and cerebral symptoms of a grave character, yet I have seen those disturbances pass off without any apparent after-effect on the kidney. I have in mind a woman who went through a gestation safely, who at one time seemed to be a hopeless nephritic. In her case I feel convinced that the reason for relief was the removal of the tonsils and subsequently the careful regulation of diet and studies of the blood.

Pathology of Nephritis

DR. HERBERT U. WILLIAMS, Buffalo: The pathology of nephritis is in a rather confused state. The old classification of nephritis is simple, but it has been modified considerably in the course of time to secure a more exact classification, and nearly every one divides nephritis now into tubular and glomerular. The chronic form of glomerular nephritis is held by many to be identical with chronic interstitial nephritis. There is great difficulty in separating these from the arteriosclerotic kidney, which resembles it closely in many cases. It is exceedingly difficult to draw a hard and fast line between the different types of nephritis not only clinically but also anatomically. To be perfectly safe, one should call every case of nephritis diffuse. The epithelium of the tubules undergoes postmortem changes. The kidney of a normal subject which has had time to undergo postmortem changes frequently shows alterations that are quite difficult to differentiate from what is normally called cloudy swelling. The epithelium of the convoluted tubules is exceedingly sensitive, and in various conditions of bacterial toxemia or in

poisoning by metals and other agencies there are marked degenerative changes in the epithelial cells. Albuminous degeneration of the epithelial cells, fatty degeneration and desquamation are seen frequently in this class of cases. It is seen in mercuric chlorid poisoning, in the acute toxemias like diphtheria and septicemia, in acute yellow atrophy of the liver, and so on. In many cases there are clear evidences of inflammation in the form of exudation into the tubules, and frequently leukocytes in and around them, and sometimes blood. Many of these cases show alterations in the glomeruli at the same time. The moderately pure type of this form of nephritis is more common than glomerular nephritis. There is a tendency to attribute the granular contracted kidney to earlier attacks of glomerular nephritis. The formation of new fibrous tissue in a kidney leading to chronic interstitital nephritis seems more and more to be attributed to the formation of fibrous tissue in response to a loss of substance rather than as a result of irritation.

We are not able at present to connect the pathologic anatomy very closely with changes in function. The classification of nephritis into glomerular, tubular, the late glomerular, the chronic interstitial, and the arteriosclerotic types is quite generally adopted, and the most interesting point is that of determining the relation of focal infection to glomerular nephritis by finding that it is caused by bacterial emboli and not entirely through the agency of toxins. Finally, a number of very high authorities are of the opinion that granular contracted kidney is closely connected with the arteriosclerotic kidney, and hard to distinguish from the latter, very largely the late results of an earlier glomerular nephritis, and possibly repeated attacks of glomerular nephritis. Mallory says that a patient who recovers from his toxemia and from his acute attack may suffer almost equally from the reparative changes that occur in the kidney.

Treatment of Chronic Nephritis

DR. JOHN R. WILLIAMS, Rochester: The most common type of kidney disease seen is that occurring in the middle aged adult who complains of some or all of the following symptoms: tiring easily, occipital headache, shortness of breath, high blood pressure, and little or no physical evidence of kidney disturbance except frequent and excessive urination at night. The blood is commonly low in urea, creatinin and phosphates. The blood sugar may be high. Edema is usually not present. Death is caused rarely by uremia, and more often by cerebral hemorrhage or failing heart. This is the well known cardiorenal type.

The next most frequently seen type is the middle-aged or even younger adult who may have pronounced eye symptoms, edema, low or high blood pressure, very little kidney reserve, urine loaded with albumin and casts, blood containing two or three times the normal amount of urine, a high blood sugar, increased blood creatinin, and phosphate retention. Death is commonly preceded by convulsions and the phenomena of uremia.

The last and much less frequently seen type is that of the young or middle-aged adult in whom the chief findings are edema, weakness, pallor, and not albuminuria, blood urea, and low sugar, perhaps lower than normal. The cholesterin content of the blood may be increased greatly; edema may or may not be influenced by the salt content of the diet. The functional capacity of the kidney is fairly normal to the usual clinical tests. The patient suffers very little headache or from other symptoms commonly seen in kidney failure.

The first and one of the most important steps in the treatment of any type of kidney disease is to rid the body of all focal infections. In the treatment of the cardiorenal type, if the patient is not harboring infection, the most important measure is rest, both mental and physical. If the patient has a good functional kidney capacity, he should be put on a low, simple, general diet. All chemical irritants and foods containing quantities of animal extractives, bacteria and bacterial products should be excluded from the diet. The patient should be allowed to have some meat and eggs. In severe cases of the second type the best measure is to put the patient at rest and give him a limited milk and fluid diet, as suggested by Karrel. I prescribe for the first few days 1 quart of milk, 1 pint of water, and either another pint of lime water or some salt of calcium, either the carbonate or the lactate, in half gram doses, several times daily. The tincture of iron or ferrous carbonate, in liberal doses, is also given. In the third type the diet should be more liberal and should contain a large amount of protein. As many as from 8 to 10 ounces of meat may be very helpful. Fluids should be restricted. If there is evidence of salt retention, its use should be curtailed; otherwise it may be sparingly permitted.

DISCUSSION

DR. A. F. CHASE, New York: Weakness, anemia, and deficiency of the blood can be overcome by large amounts of eggs, meat and albumin. I do not give a large protein diet owing to the number of cases of mixed types. In the interstitial type of nephritis, in which there is considerable retention of products of nitrogen metabolism in the blood, one should give a low protein diet to maintain body strength. There has been great danger in giving too low a diet. The pendulum has swung too far in efforts to eradicate sugar quickly from the urine and by lowering the amount of protein in the blood too quickly. For this reason I do not agree with Dr. Williams in giving too low a diet because one must consider the patient's body strength. There is a distinct advantage in giving mineral salts. A patient with interstitial nephritis should take a large vegetable diet, with an ample amount of mineral salts in the right proportion to overcome the tendency to anemia. In this type of cases profound anemia is not given sufficient attention. The reason the general practitioner does not give heavy vegetables in nephritis is that the patient will not take them; but one can give an intelligent patient vegetables if they are puréed, mashed thoroughly and put through a colander. In this way one can make use of a large variety of vegetables. I give calcium in adequate quantities to eliminate phosphates.

DR. A. A. JONES, Buffalo: In discussing the pathology of nephritis we should bear in mind the changes that occur in the kidney in cases classified clinically as purely interstitial, purely cardiorenal, or purely parenchymatous. Some years ago we were apt to disregard the glomerular element in chronic nephritis and to look on the cardiorenal cases as primarily interstitial cases. The glomeruli do not suffer early from the changes occurring around the tubules. The interstitial changes follow cellular changes in the glomeruli, and there is destruction of many of the glomeruli before an abundant interstitial new formation occurs. In the treatment one should include careful consideration of the causes of the disease if they can be discovered, so that focal infections should receive attention as carefully as dietary regulations.

CAPT. THOMAS W. JENKINS, Albany: We have had several cases of acute nephritis among the soldiers. One patient, who died following an attack of mumps, had only albuminuria. The kidneys did not show any marked change. In one case that interested me more than any other the patient was a man who, through intensive training for a commission, became ill after paratyphoid inoculation and developed one of the worst cases of nephritis I have ever seen. His urine was loaded with epithelium, and he died in the second week of illness.

DR. ALBERT E. LARKIN, Syracuse: Many of these patients are affected in more than one part of the kidney, and for that reason each case demands individual treatment. It is difficult to lay down any hard and fast rules of treatment. All are agreed that the best treatment for them is the same as for arteriosclerosis, namely, prevention.

DR. JOSEPH R. WISEMAN, Syracuse: The work of Dr. Hunt is particularly praiseworthy. In those cases in which a streptococcus was found, Dr. Hunt thinks that the tonsil is a dangerous one and should be taken out, and according to his case reports he has obtained excellent results, although one now and then sees patients with chronic nephritis and diseased tonsils in whom the removal of the tonsils is not followed by improvement.

Dr. Herbert E. Sperry, Rochester: I should like to ask how often nephritis is caused by syphilis.

Dr. Weinstein, New York: I have always been under the impression that nephritis, like a degenerative process in any other organ, is due to some infection. In two or three generations of one family one will find that the offspring are apt to suffer from nephritis as if there was a specific liability of some particular tissue to disease. With regard to diet, I have put patients on a rather low protein diet and am never afraid of the color of meat. I allow a patient to have good steak or poultry, provided it is not taken in excessive quantity. The Karrel diet is a well etablished therapeutic procedure in cases of nephritis with edema. In cases with high blood pressure one should not forget to employ digitalis.

Dr. Albert A. Epstein, New York: There is a uniformity of opinion regarding the renal type of disease in which the disturbances are purely metabolic. There is no reason why the renal function should not be concomitant with the metabolic disorder, so that there are cases in which there are mixed conditions. In such cases the method of treatment must be somewhat different from the one set down originally.

Dr. Herbert U. Williams, Buffalo: In cases of congenital syphilis the body is found riddled with organisms and gummas in the kidney. In regard to focal infections, one method of great value would be to examine the urine for long periods for organisms.

Prognosis of Surgical Tuberculosis of Kidney

Dr. William F. Braasch, Rochester, Minn.: In considering nephrectomy for early unilateral tuberculosis, the factors to be considered are age, sex, coincident tuberculosis in other organs or tissues, the duration of the symptoms, the severity of the infection of the urinary tract, and whether there is or is not bilateral involvement. Renal tuberculosis occurs from 25 to 40 years of age. Beyond the age of 60 or 70 years renal tuberculosis is of rare occurrence. We have operated on three patients up to 10 years of age. In the meantime, we have seen forty cases in children up to 10 years of age, not operated on because renal tuberculosis in children is very frequently a part of a general tuberculosis. The children on whom we have operated were seen early, and tuberculosis was not found present elsewhere. It is customary not to operate on children at once, because the majority of patients sooner or later show other evidences of tuberculosis and their resisting power will be low.

The time to operate is between 25 and 40 years of age, as the mortality increases steadily with the advance in years. The greatest mortality occurs in patients from 50 to 70 years of age. The lowest mortality from operative intervention occurs in patients from 15 to 20. The influence of complications on the mortality is important. The majority of patients have evidences of tuberculosis in other organs of the body. In only 5 per cent. was the renal tuberculosis complicated by acute pulmonary tuberculosis. Ninety per cent. of the cases of renal tuberculosis had evidences of an old pulmonary tuberculosis. Of the cases of pulmonary tuberculosis complicated by renal tuberculosis, twenty-one in number, 40 per cent. terminated fatally, which is twice as high as the mortality from renal tuberculosis uncomplicated by pulmonary tuberculosis. However, if we had not operated on patients with both pulmonary and renal tuberculosis, they all would have died. It is inconceivable to think of a spontaneous cure of renal and pulmonary tuberculosis.

The removal of the epididymis when enlarged or markedly inflamed, with secondary infection, is unquestionably advisable following nephrectomy. It is our experience at the Mayo Clinic that the caseating kidney offers a much better prognosis and much less mortality than miliary tuberculosis. In miliary tuberculosis scattered over the surface of the kidney the mortality is almost twice as high as it is when caseation is present.

Dr. Benjamin S. Barringer, New York: It is essential not to operate on the kidney without the previous use of the cystoscope. The fact that one often sees enormous vessels of the kidney and comparatively infrequently notices hydronephrosis shows there is something wrong with the anomalous vessel theory.

Dr. Ernest Watson, Buffalo: The pyelogram is the only measure we can rely on with any certainty in making an absolute diagnosis in these cases, particularly if they do not show evidence of infection. Oftentimes a dilated ureter and dilated kidney pelvis will not give evidence without examination of the ureters.

Dr. George Stark, Syracuse: I recall sixty cases of renal colic with hydronephrosis in which symptoms disappeared following dilatation. In cases of pyelitis one can bring about more cures by dilating and irrigating the pelvis of the kidney than by lavage alone.

Dr. Wolf, New York: Tuberculous kidney is operable in the early stage, and the prognosis is excellent. I recall two such cases, one of which was a case of bilateral tuberculosis which I saw two years ago. The other was a large cystic kidney in which pressure on the right side was demonstrated, and the cystoscope showed a purulent secretion. I removed the kidney in the case of bilateral tuberculosis, and two years after the operation the girl was healthy. Cystitis is an early and a late symptom. It is the last symptom to disappear in tuberculosis of the urinary tract.

Dr. Joseph F. Shears, New York: Stricture of the ureter is more common than most practitioners admit and is probably a cause of hydronephrosis.

Trench Fever

Major Alexander Lambert, New York: Commissioner Murphy early last summer informed me that it was his desire I should build up as good and scientific an organization as it was possible to do. He formed a research committee. He obtained an appropriation of $100,000 and said we could use as much of this amount as in our judgment seemed best, without restrictions, and asked us to decide on what was best to be done. He obtained the cooperation of the Medical Corps of the British Army and of the French Army, and the three Medical Corps met every month as a research medical society. They have given to the American, British and French surgeons their best experience and ideas, and have placed our men in a position to go on with research work in medicine and surgery in 1918. Otherwise we should have had to work out and struggle over the same problems that the French and British have done before. This cooperation has been of the greatest help, and is one of the best things we could have done to solidify the Medical Corps and give aid to the army and surgeons that need it.

As to trench fever, its transmission and origin have been solved. Trench fever is a curious break-bone fever that has a sharp, shooting temperature. The temperature rises to 103 and 104 F., with aches of an intense character in the insertion of the muscles, and then it drops. Again, it rises for four or five days and takes on the character of a regular recurring fever. It cannot be told, except by blood cultures, from the recurrent infectious fever of Weil. No organism has been found for it. You cannot transmit it to any animal. We experimented with everything up to monkeys and were unable to produce the fever. We realized that we must ask for volunteers, and a curious thing is that some of the men who worked with General Gorgas in Cuba in connection with yellow fever and were volunteers there were with us. Colonel Ireland, who was on the research committee, worked out the line of research in conjunction with General Wood, and Colonel McCoy was chief of staff. Colonel Ireland took the necessary orders, asked for volunteers, and of the 500 men who offered to go, sixty were accepted, and within six weeks from that time, through experimental work, it was found that trench fever was transmitted by the bites of body lice. They worked with the body lice in the trenches and worked with the lice they secured from London. Trench fever was the cause of 10 per cent. of the English army in the last year being on the sick list when these men ought to have been in the trenches. No man dies of the fever, but it disables him for two or three months. This discovery has solved the question, and it saves from 8 to 10 per cent. of the active force. This the Red Cross has succeeded in doing.

Current Medical Literature

AMERICAN

Titles marked with an asterisk (*) are abstracted below.

American Journal of Diseases of Children, Chicago

June, 1918, 15, No. 6

1 *Methods Used in a Class for Undernourished Children. C. H. Smith, New York.—p. 373.
2 Infant Feeding: Calcium in Its Relation to Absorption of Fatty Acids. A. W. Bosworth, H. I. Bowditch and L. A. Giblin, Boston.—p. 397.
3 Nutrition and Growth of Newborn Infants. W. R. Ramsey and A. G. Alley, St. Paul.—p. 408.
4 Evidence that Summer Diarrhea is an Infectious Enteritis. J. Zaborsky, St. Louis.—p. 413.
5 Lymphatic Disease in Children Simulating Appendicitis; Report of Cases. H. deB. Baras, Ann Arbor, Mich.—p. 421.

1. Methods Used for Undernourished Children.—During the past few years attention has been repeatedly called to the fact that a large number of children in this country are undernourished. Nov. 1, 1916, a nutrition class was started in the outpatient department of Bellevue Hospital as an experiment to determine how much could be done to improve the nutrition of undernourished children when handled in large numbers. The methods used in this class have been worked out in the children's tuberculosis class and other classes at the Vanderbilt Clinic. The general plan which has been kept in mind has been to make a careful diagnosis, to correct remediable physical defects, to determine and correct any economic factors that have a bearing on the case, and to try to improve the hygiene and diet of the child by every possible means. A printed slip with directions as to the general care of the child and a diet list are given to every mother. At the first visit the attention of the mother and child is called to the food exhibit, as an aid to impressing on their minds the elements of a proper diet. The visual impression made on the mother and child adds tremendously to the significance of the printed list of goods given out on the diet list. Class talks are given frequently to groups of mothers. Mothers are urged to return once a week. In extreme cases, especially when there is marked anorexia, a complete rest cure is given. Weight charts are used for every child. A photograph is taken of every child in the class, and is pasted on the back of the weight chart. Home record sheets are used for the purpose of having the child or mother record what happens to the child each day. An analysis of 110 cases has been made to determine the results of the class experiment. It has been possible to make 57 per cent. of the children gain at 1.7 times the average rate for their ages, and 22 per cent. at about the average rate, or a total of 79 per cent. who have gained at or better than the average rate. Of the remaining 21 per cent., there is one or more easily ascertained reasons for the failure in every case. These results have been obtained under the most adverse circumstances. The problem of infant mortality has been solved in large part by means of classes for teaching mothers the care and feeding of infants.

American Journal of Medical Sciences, Philadelphia

June, 1918, 155, No. 555

6 *Sensitized Vaccines in Prophylaxis and Treatment of Infections. R. L. Cecil, New York.—p. 781.
7 Character Study of Hemiplegic Epileptic. L. P. Clark, New York.—p. 796.
8 *Fractional Estimation of Gastric Contents: Effects of Antacid Medication on Gastric Acidity and Secretion. B. B. Crohn, New York.—p. 801.
9 Relapsing Fever Endemic in Colorado. J. J. Waring, Denver.—p. 819.
10 *Vaccine for Treatment of Bronchial Asthma; Report of Twenty Cases. J. M. Hutcheson and S. W. Budd, Richmond, Va.—p. 826.
11 *Atmospheric Air in Upper Digestive Tract. J. L. Kantor, New York.—p. 829.
12 Vital Stains and Central Nervous System. L. J. Pollock and W. T. Cluney, Chicago.—p. 857.
13 *Circulatory Reactions to Graduated Work in Normal People and in Those with Cardiac Insufficiency. T. B. Barringer, Jr., New York.—p. 864.
14 Perforated Gastric and Duodenal Ulcer. Statistical Report of Fifty-Nine Cases. F. J. Scully, Chicago.—p. 874.

6. Sensitised Vaccines in Infections.—Cecil employed sensitized vaccines in a series of forty-seven cases, which include twenty cases of prophylactic vaccination against typhoid and twenty-seven cases of therapeutic vaccination against gonococcus, streptococcus, *Staphylococcus aureus* and tuberculous infections. The sensitized typhoid vaccine produces a somewhat milder reaction than ordinary typhoid vaccine, and probably gives just as high an immunity. At the present time, however, the evidence for its superiority is not sufficient to justify the substitution of sensitized for ordinary vaccine in practice. In the various infections treated with sensitized vaccines the results were, as a rule, no better than would have been expected with ordinary vaccine. It happened that in a few instances recovery followed the administration of sensitized vaccine after treatment with ordinary vaccine had failed. This may have been due to the fact that larger doses could be employed without untoward symptoms. The chief objection to the general use of sensitized vaccines is the increased labor and time necessary for their preparation. At the present time it would seem desirable to limit their use to the treatment of infections in which there is hypersensitiveness to ordinary vaccines or in which the latter have proved inefficacious.

8. Effects of Antacid Medication on Gastric Secretion.—Crohn believes that the use of fractional doses of the alkalis distributed over the course of digestion is the most efficient and physiologic method for the employment of these agencies; for this purpose magnesium oxid is the most dependable and best suited salt. Based on these studies it seems very questionable whether prolonged use of the alkalies leads to any permanent diminution of the acid secretion of the stomach; in fact, it is as likely that the opposite effect is produced. A lasting relief of hyperacidity is not to be sought in antacid medication, nor in olive oil or atropin. It is more likely to be found in the proper regulation of diet and restriction of dietary errors as well as in the general control of the hygiene and manner of living of each individual patient under professional care.

10. Vaccine for Bronchial Asthma.—Certain observations of the writers, derived from the study of a considerable number of cases of asthma, have strongly suggested the possibility of the presence of the specific protein in the bronchial secretions of the patient himself, and also that this protein may be recovered in suitable form for use in bringing about immunity. The vaccine the authors use is made in the following manner: 1 c.c. of washed sputum is incubated in 10 c.c. of broth and 1 or 2 drops of guinea-pig serum for a period of forty-eight hours. At the expiration of that time the culture is standardized and killed by heat of 60 C. for a period of two hours. Further decomposition is prevented by adding phenol until a 1 per cent. solution results. This is cultured out to insure sterility of suspension. The vaccine is then diluted with normal saline until each cubic centimeter of the suspension contains 500,000,000 to 1,000,000,000 organisms. The initial dose is 5 minims and each subsequent dose is increased by 1 minim. The authors do not increase beyond 15 minims, although they may continue the treatment several weeks after this amount has been reached.

The effect of this plan of treatment has been observed in twenty cases of typical bronchial asthma. In twelve of these cases complete relief from attacks was experienced after from one to five injections of the vaccine and this relief has persisted up to the present time. The longest period of freedom from symptoms is sixteen months, the shortest six weeks. In five cases distinct improvement has been noted either in the frequency of the seizures, their severity, or their duration. In three of these cases improvement occurred only after a second vaccine had been made and administered at shorter intervals than the first. In two cases no effect at all was produced. One of these patients was an elderly man with emphysematous lungs and a history of asthma extending over twenty years. Asthma in the other case had followed injury

to the chest and roentgen-ray examination revealed ununited fractures of several ribs. In one case administration of the vaccine seemed to increase the intensity of the paroxysms, a result which appeared to be explained by the fact that too long a time was allowed to elapse between injections.

11. **Atmospheric Air in Upper Digestive Tract.**—The results of his study have convinced Kantor that in general, gaseous accumulations in the upper digestive tract have atmospheric air as their basis. This air is introduced by ordinary swallowing or by an adaptation of the swallowing mechanism known as gulping. The differences between the swallowing of air and that of food depend to a large extent on the influence of gravity. As a result the swallowing mechanism shows certain peculiarities which are described in this paper. By means of fluoroscopic observations it can be demonstrated that the so-called swallowing sounds are produced by the entry of air into the stomach. A close study of the mechanism of deglutition based on a review of the literature and on original roentgen-ray observations shows the advantage of describing the complete act of swallowing as consisting of three instead of the classic two periods. These three periods are the buccopharyngeal, the esophageal and the cardiogastric.

13. **Graduated Work in Cardiac Insufficiency.**—Barringer claims that the occurrence of a delayed rise in systolic blood pressure after work indicates that the preceding work has either overtaxed or is on the point of overtaxing the heart's reserve power. The presence of a delayed rise can be determined by the infrequent method of plotting the pressure curve with almost as much certainty as by the frequent method. Experiments on normal people and on patients with cardiac insufficiency showed that no definite relation existed between the time required for the pulse rate to return to normal and the condition of the cardiac reserve power.

Arkansas Medical Society Journal, Little Rock

May, 1918, 14, No. 12

15 Case Records for General Practitioner. S. W. Douglass, Eudora.—p. 237.
16 Early Diagnosis and Treatment of Tabes Dorsalis. L. Thompson, Hot Springs.—p. 239.

Boston Medical and Surgical Journal

May 30, 1918, 178, No. 22

17 Roentgenology in American Army. F. Wheatley, Jr., North Abington.—p. 727.
18 Physician and Psychology. J. D. Taylor, East Boston.—p. 730.
19 Renal and Ureteral Stone. B. Tenney, Boston.—p. 731.
20 Mobilization of Knee Joint in Suspension Traction Treatment of Fracture of Femoral Shaft. G. A. Moore, Brockton.—p. 736.

June 6, 1918, 178, No. 23

21 Congenital Pyloric Stenosis. W. E. Ladd, Boston.—p. 767.
22 *Clinical Study of One Hundred and Fifty Cases of Bronchial Asthma. F. M. Rackemann, Boston.—p. 770.
23 Control of Communicable Diseases. D. M. Lewis, New Haven, Conn.—p. 772.
24 Idiopathic Epilepsy. E. A. Tracy, Boston.—p. 775. To be continued.

22. **Clinical Study of Bronchial Asthma.**—One hundred and fifty cases of asthma were studied by Rackemann. The object of study was threefold: 1. To discover the cause of asthma or to identify the offending foreign protein in each patient. 2. To separate the patients having the same cause of asthma into groups. 3. To see whether there was one or more symptom or sign present in each patient and not present in normal nonasthmatic persons which might indicate a fundamental disturbance of anatomy or physiology in these patients as a group.

Each patient was studied by taking a very careful history, by making a complete physical examination, including chest, roentgenograms, special examination of the nose and throat by experts, electrocardiogram, and blood smears when necessary. In addition, skin tests, were made in a large proportion of the patients. Water-clear, sterile solutions of various protein substances were diluted so that each contained the same quantity of total nitrogen per cubic centimeter. These solutions were then injected intradermally. In normal nonasthmatic persons and in certain asthmatics, there was no result showing that the solutions were not irritating. Certain asthmatics gave positive tests. These consisted of a typical urticarial wheal surrounded by a zone of bright erythema, which appeared within ten minutes and was evident for perhaps forty-five minutes or even longer. From the history and skin tests, it has been possible to group 80 per cent. of the patients.

Twenty-eight per cent. of the cases had extrinsic asthma, while almost twice the number, or 53 per cent., had intrinsic asthma. Of the extrinsic cases twenty-four gave a definite history of aggravation of asthma during the summer months, and all but five gave a positive skin test to extracts of one or more pollens. In about half of all these cases the asthma ceases abruptly with the first frost. Sixteen cases gave a positive skin test to horse dander protein and gave histories at least compatible with, and often too obvious of, susceptibility to horses. Twenty-one other patients gave a positive skin test to horse dander protein but are not classed as horse asthmatics because there is nothing in their history or in their daily life which made it seem reasonable or even possible that horse dust or horse "emanation" might cause their asthma. Only two cases in this particular series gave a history of violent susceptibility to food.

Of the intrinsic cases in five derangement of the gastrointestinal tract seemed to be a possible cause. In twenty-four cases the attacks of asthma came on only after a "cold" and recurred only at relatively long intervals. Winter asthma and chronic bronchitis are included in thirty cases of emphysema. Tuberculosis was found in six cases. Ten cases were associated with pregnancy (2), with catamenia (2), with enlarged bronchial lymph nodes (3), with lordosis (1), with obscure circulatory disturbances (2). One hundred and eighty-four differential blood smears made in 123 cases have shown a relatively constant eosinophilia averaging about 5 per cent., but there has appeared no significant difference between the eosinophilia in cases of extrinsic from that in cases of intrinsic asthma, nor any significant difference in the counts made during and between the asthmatic attacks in either divisions.

Cleveland Medical Journal

May, 1918, 17, No. 5

25 William Beaumont, Pioneer Physiologist of North America. T. L. Patterson, Kingston, Ont.—p. 287.
26 Double Recurrent and Bilateral Tubal Pregnancies—Analysis of Literature and Personal Cases. A. P. Heineck, Chicago.—p. 306.
27 Case of Postoperative Obstruction. A. G. S. Louis, Cleveland.—p. 319.

Journal of Cutaneous Diseases, Chicago

May, 1918, 36, No. 5

28 Ossification in Case of Scleroderma. S. Pollitzer, New York.—p. 271.
29 *New Form of Punctiform Keratodermia. S. I. Matsumoto, Japan.—p. 280.
30 Varioliform Macular Atrophy of Skin—Hitherto Unrecognized and Undescribed Atrophic Affection of Skin. M. L. Heidingsfeld, Cincinnati.—p. 285.
31 *Titration of Complement for Its Power to Combine in Syphilitic System. A. W. Stillians, Chicago.—p. 289.

29. **Punctiform Keratodermia.**—Matsumoto reports a peculiar type of punctiform keratodermia existing on the palms occurring in a girl, aged 19. On the palmar surface of the hands and fingers, strictly confined to the flexures of the joints, there were numerous miliary, horny, punctiform efflorescences, yellowish or light brownish in hue, from pinpoint to poppy seed in size. The primary lesions were minute, slightly elevated, at times scarcely visible papules, oval or roundish in shape, showing a slight degree of hyperkeratosis. They usually appeared isolated, but some coalesced to form irregularly shaped eruptions and often showed slight desquamation in the center, so that some were slightly cupped at the summit. But a comedolike horny plug or central conical plug was never seen. The palms showed no hyperidrosis. Diffuse keratosis was not present. No dilated sweat orifices were noticed; neither was an excentric growth of the lesion demonstrable. The distribution and arrangement of the lesions was quite peculiar and exhibited on both hands a well marked symmetry. The soles were intact. The eruption appeared early in her childhood (before she was 5 years of age), but the patient was unable to give the exact date of its outbreak and course, as there was no subjective symptom. The disease ran an extremely slow course, was beyond doubt. No hereditary taint was ascertainable. The patient was afflicted,

furthermore, with so-called tuberculids on the ears, and the extensor surfaces of the elbows and knees.

31. Estimating Value of Wassermann Reaction.—Stillians claims that the use of a mixture of glycerinized strong positive serums, titrated with each set of Wassermann tests as a positive control, gives an accurate idea of the strength of the Wassermann reaction. Titration of complement against the combination of antigen with a fraction of the titer of this positive control gives valuable information as to the combining power of complement in the syphilitic system. By the use of this method of titration, variations in strength of the Wassermann reaction can be minimized. Old complement is apt to lose its power to combine in the syphilitic system before its hemolytic value fails. Such variations are detected and estimated by the new method of titration.

Journal of Urology, Baltimore

April, 1918, **2**, No. 2

32 War Nephritis. P. Ameuille.—p. 51.
33 *Urinary Antisepsis: Studies of Antiseptic Properties and Renal Excretion of Compounds Related to Phenolsulphonephthalein. E. G. Davis and E. C. White, Baltimore.—p. 107.
34 Developmental Stages of Human Seminal Vesicles. E. M. Watson, Baltimore.—p. 129.
35 *Effects of Thorium and Other Substances on Renal Parenchyma when Retained. J. E. Burns and P. B. Hopkins, Baltimore.—p. 145.

33. Urinary Antisepsis.—The ideal internal urinary antiseptic must be a drug which is chemically stable, nontoxic and nonirritating to the urinary tract; which is antiseptic in high dilution in urine, regardless of the reaction of the latter; and which is eliminated unchanged in high percentage by the kidney. Davis and White claim that there is no such drug known. A consideration of the properties possessed by phenolsulphonephthalein, however, shows that this compound comes very close to filling all above requirements. The property possessed by phenolsulphonephthalein, by virtue of which is it so rapidly eliminated by the kidney, is by no means limited to this compound. Several other more or less closely related compounds show the same striking "renal affinity," and might also be of value in testing renal function were it not that phenolsulphonephthalein itself is so nearly ideal for this purpose. Compounds of the xanthone class, that is, phthaleins (though not necessarily sulphonephthaleins) in which there is an oxygen atom linking the two phenol groups, show a similar remarkable "renal affinity." The bromination of these compounds, both sulphonephthaleins and xanthones, almost completely prevents the excretion, but chlorination merely diminishes the excretion. Iodination prevents excretion or gives rise to elimination of the substance in a modified form. It has been possible to establish a certain relationship between chemical structure and renal excretion, and to predict, with a reasonable amount of accuracy, which drugs will and which will not be excreted. The synthesis of germicidal compounds, very closely related to the types excreted, has been accomplished; one of these compounds, rhodamin, was excreted and would have been satisfactory but for the interfering action of the urine; another compound "mercury fluorescein," has been found to be rapidly excreted and to produce germicidal urine. The authors hope that their experiments may call attention to the inadequacy of the urinary antiseptics in general use, and stimulate interest in the possibilities offered by synthetic chemistry. The investigation in being continued and the properties of various related compounds are being studied.

35. Effects of Thorium on Renal Parenchyma.—Burns and Hopkins found that thorium solution retained in the renal pelvis has no damaging effect whatsoever on the renal parenchyma. Cortical abscesses and pyelitis are due to the presence of infection and not to the retained solution. The cortical changes after the introduction of thorium solution are purely pressure phenomena and are the same as after either simple ligation of the ureter or the introduction of sterile water or normal salt solution into the renal pelvis. Collargol retained in the renal pelvis causes not only great damage to the kidney itself but systemic poisoning most often resulting in death. Ligation of the ureter either alone or after the injection of some solution causes hydronephrosis. The size of the hydronephrosis depends entirely on the development of the compensatory collateral capsular circulation.

Kentucky Medical Journal, Bowling Green

June, 1918, **16**, No. 6

36 Border Line Tonsils. W. B. McClure, Lexington.—p. 229.
37 Acute Intestinal Obstruction. G. A. Hendon, Louisville.—p. 232.
38 Diagnosis and Treatment of Trachoma. G. F. Doyle, Winchester.—p. 238.
39 Gunshot Wounds of Abdomen. D. W. Barrow, Lexington.—p. 243.
40 Gunshot Wounds in Civil Life with Treatment. W. Bach, Jackson.—p. 246.
41 Epistaxis, Cause and Treatment. W. J. Thomason, Newport.—p. 249.
42 Venereal Disease Clinic. S. Graves, Louisville.—p. 251.
43 What Physicians Who Are Not Accepted in Medical Reserve Corps Can Do. M. Pennington, Mount Vernon.—p. 258.
44 Talipes. J. A. Davis, Covington.—p. 260.
45 Radium; Some of Its Therapeutic Uses. L. Frank and L. W. Frank, Louisville.—p. 263.
46 Hypothyroidism. F. C. Askenstedt, Louisville.—p. 268.
47 Celiohysterotomy for Puerperal Eclampsia and Placenta Previa. W. H. Taulbee, Maysville.—p. 270.
48 Surgical Complications of Typhoid. R. L. Woodard, Hopkinsville.—p. 272.

Medical Record, New York

June 8, 1918, **93**, No. 23

49 Biographic Sketch of Four Physicians of Napoleonic Era. P. E. Bechet, New York.—p. 969.
50 Low Diastolic and High Pulse Pressure in Three Cases of Aneurysm of Aorta. C. E. Stewart, Battle Creek, Mich.—p. 972.
51 Weak Feet in Children. J. Grossman, New York.—p. 974.
52 Localizing Posterior Gonorrheal Urethritis. H. J. Millstone, Chicago.—p. 979.
53 Eugenics: Its Relation to Mental Diseases. J. J. Kindred, Astoria, L. I.—p. 981.

Nebraska State Medical Journal, Norfolk

May, 1918, **3**, No. 5

54 Precancerous Conditions of Breast. M. G. Wohl, Omaha.—p. 153.
55 Tuberculosis in Children. F. Clarke, Omaha.—p. 158.
56 Changes Necessary to Future Practice of Medicine. C. A. Roeder, Omaha.—p. 160.

Neurological Bulletin, New York

May, 1918, **1**, No. 5

57 Case of Double Primary Athetosis. M. A. Starr, New York.—p. 205.
58 *Case of Myxosarcoma of Temporal Bone with Extension into Posterior Cranial Fossa Presenting Unusual Symptoms. C. A. Elsberg, New York.—p. 207.
59 Ruptured Aneurysm of Right Middle Cerebral Artery. C. A. Elsberg, New York.—p. 210.
60 Borderline Psychiatry. S. R. Leahy, New York.—p. 212.
61 Social Maladjustment, Compulsion Neurosis in Young Man Turning Serious Activities of Life Into Bizarre Distortions. F. M. Hallock, New York.—p. 219.
62 Morphology of Gray Matter in Brain Stem of Vertebrates. R. Hoyt, New York.—p. 227.

58. Myxosarcoma of Temporal Bone.—Three years ago Elsberg's patient developed a large swelling in the left submaxillary region. A mass of glands were removed which was said to have been of a chronic inflammatory nature. After the operation she noticed that the left angle of her mouth "drooped" more than it had ever done before. She recovered satisfactorily from the operation and did not have any new symptoms until September, 1916. About one and a half years prior to making this report, after a severe mental shock, the patient began to have frequently headaches and attacks of dizziness. The headaches recurred very frequently and were uninfluenced by treatment. On the basis of the symptoms present at this time the diagnosis of a tumor in the left cerebellopontine angle was made, and the patient was operated on. The dura over the cerebellum was exposed by a typical bilateral suboccipital craniotomy. As soon as the dura covering the lower part of the left hemisphere was exposed by the removal of the occipital bone, considerable yellow gelatinous material began to extrude from the left posterior fossa, and after the dura had been depressed, the left posterior fossa was found to be entirely filled by this material. Considerable of the gelatinous matter was removed with a spoon. There was some bleeding from the jelly-like substance, and it was evident that the entire side of the fossa

was filled up by the mass. The wound was closed in the usual manner. The pathologist reported that the tumor was a myxosarcoma.

Aside from the rarity of this form of tumor in this location, the symptoms and clinical signs presented by the patient were of extraordinary interest and most confusing. In each attack of illness the left side of the body, and especially cranial nerves on the left side, were affected. An attack of smallpox followed by otitis, left behind a paralysis and atrophy of the left side of the tongue and diminished hearing of the left ear. A postpartum attack—probably one of cerebral embolism—added a paresis of the left side of the face and a weakness of the left arm with paralysis of the left cord. After the removal of glands from the left side of the neck, a branch of the left facial nerve was found to be completely paralyzed (ramus marginalis mandibulae). Finally, the patient developed symptoms which were clearly referable to the left lobe of the cerebellum and the left posterior fossa—ataxia, nystagmus, adiadochokinesis, hypesthesia over the distribution of the left trigeminus, complete paralysis of the left facial, complete nerve deafness in the left ear and loss of the normal caloric reactions on that side.

New York Medical Journal

June 8, 1918, 107, No. 23

63 Pneumonia and Its Treatment. S. S. Cohen, Philadelphia. —p. 1057.
64 Self Treatment. E. E. Smith, New York.—p. 1063.
65 Treatment of Feebleminded. W. B. Cornell, New York.—p. 1067.
66 Acute Infectious Jaundice (Spirochetosis Icterohemorrhagica). C. Herrman, New York.—p. 1068.
67 Antitoxin Dose in Diphtheria. A. J. M. Treacy, Philadelphia. —p. 1071.
68 Fluoroscopy in Diagnosis of Chest Conditions. A. F. Holding and M. Greenwald, New York.—p. 1072.
69 Transplantation of Mucous Membrane of Mouth for Various Diseases and Burns of Cornea. R. C. R. Denig, New York.—p. 1074.
70 Plea for Modified Sluder Operation. I. Grushlaw, New York. —p. 1075.
71 Bloodless Tonsillectomy. P. V. Winslow, New York.—p. 1077.
72 Surgical Treatment of Penetrating Wounds of Thorax. H. M. W. Gray, Aberdeen, Scotland.—p. 1078.
73 Rehabilitation of Rejected. W. H. Sheldon, New York.—p. 1081.

FOREIGN

Titles marked with an asterisk (*) are abstracted below. Single case reports and trials of new drugs are usually omitted.

British Medical Journal, London

May 18, 1918, 1, No. 2994

1 *Intravenous Injection in Wound Shock. W. M. Bayliss.—p. 553.
2 Ten Thousand Recruits with Doubtful Heart Conditions. S. R. Wells.—p. 556.
3 Epidemic Polioencephalitis; Report of Cases. C. H. Melland. —p. 559.
4 Nephelometric Estimation of Quinin in Blood and Urine. I. J. Lipkin and W. Ramsden.—p. 560.
5 *Sterilization of Skin and Other Surfaces by Mixture of Crystal Violet and Brilliant Green. V. Bonney and C. H. Browning. —p. 562.

1. **Intravenous Injection in Wound Shock.**—The general practical conclusion to be drawn from Bayliss' lecture is that the main factor in the successful treatment of wound shock is to ensure an adequate supply of blood—that is, of oxygen—to vital organs, especially to the nerve centers. This is most simply done by intravenous injection of gum solution, which does not appear to be, in most cases, inferior to blood. When very great hemorrhage has occurred, it would seem reasonable that blood transfusion should be preferred. A solution of gum arabic of 6 per cent. strength has been found, both in the case of wounded men and in lower animals, to maintain blood pressure indefinitely. It does not leave the blood vessels. Gum is quite innocuous, even in a volume equal to one half of the total blood volume, or an injection of more than a liter and a half in man. It produces no hemolysis or agglutination in man and does not increase the viscosity of the blood. Since it contains no protein, anaphylaxis in case of a later injection would not be expected, and, tested on guinea-pigs, was found not to occur. Gum is chemically a very inert substance and is not foreign to animal metabolism. It consists of derivatives of galactose and of arabinose. Galatose is a natural sugar present in milk. Arabinose appears in the urine in pentosuria and appears to arise from galactose by removal of carbon dioxid (Neuberg). Since commercial products contain small amounts of calcium and potassium salts, there is no need to add them. All that is necessary is the addition of 0.9 per cent. of sodium chlorid, and tap water may be used. The solution must be filtered through flannel or other convenient medium and then sterilized. A strength of 6 per cent. is probably the best for routine use. In practice, even 3 per cent. has been found greatly superior to saline solutions, but it is clear that its osmotic pressure is not the optimal one.

If the use of sodium bicarbonate is thought necessary, it is best given by stomach or rectum. But it has not yet been demonstrated that the symptoms relieved by bicarbonate would not be more effectively cured by raising the blood pressure. In principle it would seem to be a mistake to reduce the slight increase of acidity in the blood, since this is of value in stimulating the respiratory center, and there is no evidence that the slight increase of hydrogen ion concentration which is present in some cases of acidosis, but not always, is in any degree harmful in itself.

5. **Sterilisation of Skin With Crystal Violet and Brilliant Green.**—The method which Bonney and Browning have employed as a routine for the last two and a half years, is as follows: The solution contains 1 per cent. of a mixture of equal parts of crystal violet and brilliant green dissolved in equal parts of alcohol and water. (The powder is dissolved in the undiluted spirit first of all and the water then added.) Six hours before the operation (except in certain cases) the solution is painted over the skin of the operation area; a compress of lint soaked in the same and covered by a sheet of waterproof batiste is then applied and kept in position by a binder or bandage. This compress is removed on the operating table and no further painting done. The result is that the skin is stained an intense violet black; the staining remains unchanged throughout the operation and, indeed, for a week or two afterward. This prolonged application of the antiseptic produces no irritation of the skin, or of more sensitive surfaces such as the vulva and vagina. The theoretical advantages of an antiseptic capable of being applied in such concentration and over such a period are obvious. The epithelial squames throughout the entire thickness of this layer become permeated with the dyes. Should a squame become detached and conveyed into the wound it carries with it a definite amount of a potent but practically nonirritating antiseptic, and the skin surface exposed is not merely initially sterilized, but remains antiseptic throughout the operation. The clinical results accord with the theoretical. The very marked superiority of violet green over the commonly used iodin was strikingly demonstrated in bacteriologic experiments.

Journal of Laryngology, Rhinology and Otology, London

May, 1918, 33, No. 5

6 Intrinsic Cancer of Larynx and Operation of Laryngofissure. I. Moore.—p. 129. To be continued.
7 New Symptom of Labyrinth Fistula. S. H. Mygind.—p. 143.

Lancet, London

May 11, 1918, 1, No. 4941

8 Teaching and Training in Hygiene. H. R. Kenwood.—p. 663.
9 *Tachycardia: Occurrence in Enteric and Other Fevers. H. F. Marris.—p. 667.
10 Splints for Use in Arm, Ankle and Leg Injuries. W. Pearson. —p. 670.
11 Liquid Tight Closure and Treatment of Wounds. W. H. Taylor and N. B. Taylor.—p. 671.
12 Bladder Drainage and Irrigation. J. MacMunn.—p. 672.
13 *Fistula in Ano. F. S. Edwards.—p. 673.

9. **Tachycardia.**—A large number of cases belonging to the enteric group of fevers examined by Marris were characterized during the febrile period by a relatively slow heart rate; some developed tachycardia gradually during convalescence, a few abruptly, while the minority were conspicuous by the presence of rapid heart action throughout the disease. The cardiovascular system was repeatedly examined. In some cases the tachycardia was cardiac in origin; in some

toxic in origin. In a third group it was a vasomotor tachycardia and in a fourth group it was a postural or atonic variety of tachycardia. In a series of 650 cases of the enteric group of fevers tachycardia of sufficient degree to attract attention was observed in 75 cases; 5 of these were judged to be cardiac in origin, 40 were due to vasomotor instability, 10 were of the postural variety, and the remainder presented features suggestive of Groups 2 and 3. During the course of this investigation similar observations were carried out on the cases of tachycardia occurring in other febrile disorders. In the fatal cases, such as diphtheria, cerebrospinal meningitis, miliary tuberculosis, scarlet fever, the tachycardia was found to be of the cardiac variety. The majority of the nonfatal cases belonged to the vasomotor group and occurred during the convalescence of such diseases as diphtheria, scarlet fever, trench fever, influenza and pyrexias of obscure origin. A few of the postural variety were encountered in obscure febrile disorders with gastro-intestinal signs and symptoms.

13. **Fistula in Ano.**—In Edwards' opinion the failures are due to one of three reasons. First and foremost, the topography of the fistula is not thoroughly recognized and thus a part of the fistula's track escapes division. Second, caries of the coccyx, or even of the ischium, is a not infrequent cause of a persisting fistula, and unless this is discovered and dealt with a cure is impossible. Third, tubercle; but although a certain small proportion of fistulas are tuberculous, it is astonishing how readily healing takes place after operation in the majority. When it does not the operation wound remains open and gaping, but the fistula as such may no longer exist.

Medical Journal of Australia, Sydney

April 27, 1918, 1, No. 17

14 Practice of Anesthetics. E. H. Embley.—p. 341. To be continued.
15 Applied Comparative Anatomy. W. C. MacKenzie.—p. 344.

May 4, 1918, 1, No. 18

16 Agglutination After Administration of Typhoid and Paratyphoid Vaccines. W. K. Inglis.—p. 363 To be continued.
17 Practice of Anesthetics. E. H. Embley.—p. 366. To be continued.

May 11, 1918, 1, No. 19

18 Agglutination after Administration of Typhoid and Paratyphoid Vaccines. W. K. Inglis.—p. 383. To be continued.
19 Practice of Anesthetics. E. H. Embley.—p. 387. To be continued.
20 Prevention of Diphtheria. F. R. Legge.—p. 391.

Bulletins de la Société Médicale des Hôpitaux, Paris

March 15, 1918, 42, No. 10

21 *Black Pleurisy. L. Galliard.—p. 266.
22 *Walled-Off Spinal Meningitis. E. Leroy and J. Paraf.—p. 270.
23 Wounds of Cauda Equina. G. Guillain and J. A. Barré.—p. 272.
24 *Valvular Disease in Soldiers. P. Lafosse.—p. 283.
25 *Functional Heart Disturbances in Soldiers. A. Clerc and P. Aimé.—p. 290.
26 *Epididymitis with Meningitis and Influenza. Beaussart.—p. 294.

21. **Black Pleurisy.**—The case reported teaches that the discovery of black blood in the pleura means an old hemothorax and that infection is probably already installed.

22. **Walled-Off Meningitis.**—Necropsy showed that the ventricles were intact, which explained the negative results of puncture trephining of the ventricles in the case of meningitis in a man of 42. The spinal cavity had evidently become partitioned off from the skull cavities, but this partitioning was much lower down. In future, before puncturing the ventricle, Leroy intends to puncture the spinal cavity in the thoracic or neck region.

24. **Valvular Disease and Active Service.**—Lafosse reviewing his experience with forty-seven cases of valvular disease in soldiers, comments on the surprising tolerance of the men with valvular disease. Thirty-nine of them are doing excellent work in the way of limited service; only 8 have been invalided. Josué stated that he has examined 2,419 men with valvular disease. He restricts to the auxiliary or limited service those who have never had any disturbance from their well compensated valvular trouble. With slight transient disturbance after physical effort, he advises the auxiliary service in the same way except that he specifies that the man must be kept under medical supervision and must not do heavy work. With a tendency to dyspnea, fatigue, etc., which will probably yield to repose and treatment, the man should be temporarily invalided. With any disturbances more than the above, discharge from the army is imperative. Laubry said that in passing judgment on valvular disease—other things being equal—the age over 35, recurring infectious diseases, narrow chest, dilatation of the heart, or persisting anomalies in the arterial pressure turned the scale in favor of permanent invaliding of the men. He does not pay much heed to functional tests. His early zeal in saving men with valvular disease for limited service has been gradually dampened by the unfavorable issue in certain cases, as the exigencies even of the limited service impose a strain at times on the men, and the specialist cannot follow them about.

25. **Functional Heart Disturbances.**—Clerc and Aimé remark that a serious obstacle to the recovery of men with functional heart disturbances is often found in the men's conviction that they have organic heart disease; possibly they have been so informed by some physician. In 88 of these purely functional cases, the label had been mitral insufficiency (13); endocarditis (8); myocarditis (4), or aortic lesions (2), besides a number called merely "heart disease," but Clerc and Aimé were unable to detect any organic lesion. These divergencies are due, they say, to the exaggerated importance ascribed by some to a few fleeting extrasystoles or respiratory arrhythmia, or misinterpretation of the inorganic murmurs which were found in 58 per cent. of the men. They reiterate that a murmur, the organic character of which is not evident, does not, in itself alone, testify to a valvular lesion. In deciding whether the man is fit for duty, they lay great stress on the general state of the strength, as the strength of the heart is often only the reflection of this. They stress further the response to repose.

26. **Orchi-Epididymitis with Meningitis and Influenza.**—Beaussart has noticed that infectious diseases later are liable to cause meningeal reactions when the person has passed through meningitis at any time. In a case described, bilateral orchi-epididymitis developed in the course of meningitis and again, a year later, in the course of influenza with severe meningitic symptoms.

Journal de Chirurgie, Paris

May, 1918, 14, No. 4

27 *Trench Foot. V. Raymond and J. Parisot.—p. 329.
28 Puncture of Brain after War Wounds. C. Villandre.—p. 364.

27. **Trench Foot.**—Raymond and Parisot have found several varieties of fungus in the local lesions, blood and organs with trench foot, and they have been able to reproduce with them similar lesions in animals. Some induce, alone, similar lesions; others require the predisposing influence of wet and cold. Trench foot therefore is the result of infection of the organism by mycelian molds in the soil, which become parasites and acquire pathogenic properties under the influence of stagnation in cold water. Treatment based on this assumption has cured 99.6 per cent. of the men without loss of tissue. In prophylaxis, the main thing is to keep the feet dry; when this is not possible, to soap them well with a medicated soap—100 gm. sodium borate and 25 gm. pulverized camphor in 1,000 gm. soft potash soap. The feet and shoes are dusted with talcum containing 2.5 per cent. camphor. Greasing with grease containing 2.5 per cent. camphor may also be useful, but the main reliance is on the soaping, repeated as often as possible when conditions invite trench foot. Among the 2,861 cases in one ambulance, only 5 per cent. of the 1,098 blacks and 5 per cent. of the 242 Arabs suffered any loss of tissue, and only 0.04 per cent. of the 1,521 French soldiers. The article is accompanied with 28 illustrations or case charts.

Presse Médicale, Paris

May 2, 1918, 26, No. 25

29 *Primary Suture of War Wounds. G. Gross.—p. 225.
30 *Chronic Enteritis and Coprology. R. Goiffon.—p. 227.
31 Treatment of Furunculosis with Lappa. R. Burnier.—p. 229.

29. Primary Suture of War Wounds.—Gross' ambulance cares only for the more severely wounded, and since the system of primary suture has been systematically applied, the mortality has fallen to 10 per cent. He reiterates that every war wound which does not contain the streptococcus should be sutured as the routine measure. The wounds with the streptococcus look differently; the man's face is thin and drawn, the pulse fast, and there is no appetite. The aspect of the ward with streptococcus cases is quite different from that in other wards. It is indispensable, he emphasizes, to isolate the wounded who present the streptococcus, as this is the only infection to be feared from the standpoint of early suture. Experience is confirming more and more that anaerobes are unable to proliferate in a living body unless they find devitalized tissues with one or more aerobes. With ordinary aerobes, the process is localized; with the staphylococcus it slowly spreads, but with the streptococcus it spreads rapidly and may assume a fulminating form. As soon as the devitalized tissue has all been excised, he sutures at once while waiting for the bacteriologic findings. If ordinary aerobes are found, he leaves the suture unmolested. With the staphylococcus, he keeps a special watch over the wound to see if slow putrid infection is becoming installed, cutting a thread or two at need. If the streptococcus is found, he removes the suture at once, opens up the wound anew, and by successive clearing out of devitalized tissues combats the putrid fermentation. The anaerobes do not start trouble until about the thirtieth hour, but the bacteriologic findings are available by the sixth hour. When the primary suture was not made, he sutures the second or third day with ordinary aerobes. With the staphylococcus he waits for its regression, from the fifth to the eighth day. With the streptococcus, he waits for the spontaneous vaccination of the organism. This occurs on an average the twenty-first day, but may be earlier. It is manifested by a drop in the temperature, but does not become definite until there is no longer any general reaction or the streptococcus has entirely disappeared. In Gross' experience 78.3 per cent. of the wounds were sutured at once, and 88.8 per cent. of the sutured wounds healed by primary intention.

30. Chronic Enteritis.—Goiffon insists on the importance of examination of the stools as the indispensable aid to clinical and roentgen study of every case of inflammation in the small intestine, disease of the liver and pancreas, chronic disease of the cecum, fermentation diarrhea, mucous colitis, left colitis and sigmoiditis, intestinal ulceration, and every case of colitis of parasitic origin; also for determination of the enteric origin of certain forms of gastric dyspepsia, and of the gastric origin of certain forms of enteritis, and in differentiation of factitious and of unrecognized bowel trouble. Each of these groups he defines and describes, insisting on the importance from the military standpoint of prompt diagnosis and treatment. In wartime we must cure quickly or return the man to civilian life.

Clinica Chirurgica, Milan

May, 1918, **25**, No. 5

32 *Correction of Paralytic Talipes. A. Guaccero.—p. 449.
33 *War Wounds of Bladder. G. Mioni.—p. 473.
34 War Wounds of Knee. G. Razzboni.—p. 486.
35 War Wounds of Skull. M. Sertorio.—p. 500.
36 *Reinfusion of Extravasated Blood. R. Alessandri.—p. 504.

32. Tendon Plastics to Correct Paralytic Talipes.—Guaccero refers to paralytic deformity in the domain of the external popliteal nerve left by poliomyelitis. He has done a plastic operation of the kind on tendons in thirteen cases of severe equinus varus. Healing was by primary intention in all and the outcome has been extremely satisfactory in eleven of the cases. The ultimate results in the other two cases are not known. He utilizes the gastrocnemius and soleus by joining them to the tendons of the paralyzed antagonist muscles. By this means the foot is brought to some extent under muscular control and is held in an approximately normal position. He exposes and slits the Achilles tendon into three strips, shortens the dorsal flexor tendon, and draws one strip of the Achilles tendon through to the dorsum of the foot, and then reconstructs the Achilles tendon with what is left, as he explains with illustrations.

33. War Wounds of the Bladder.—Mioni relates that he has seen only five cases of wounds of the bladder amenable to treatment among the 4,500 wounded soldiers that have passed through his field hospital. The others with bladder wounds succumbed to associated wounds. He found packing the bladder with gauze useful in arresting hemorrhage.

36. Reinfusion of Extravasated Blood.—Alessandri quotes Kreuter's case in which a liter of blood from the ruptured liver was injected into a vein in the arm. Over 2 liters of blood had been taken from the abdominal cavity and the blood had stood outside the organism for a half hour before the infusion. The immediate results were surprisingly good, but there were other wounds which soon proved fatal. Elmendorf has also reported a similar case, reinjecting the blood drawn from a hemothorax, and the man recovered. Cases are on record in which obstetricians have successfully reinjected blood from the hemorrhage with extra-uterine pregnancy. The blood in all these cases seems to have been defibrinated; it did not display any pyrogenic property. The blood from a wound of the liver, spleen, lungs, kidneys, heart or large vessels may be regarded as practically sterile. Even if it does contain some germs, the blood itself injected with them is the most effectual means to combat them. Of course, perforation of the bowel or the presence of a foreign body, scrap of clothing, etc., would enhance the danger, and unfortunately these conditions predominate with war wounds. But the successes reported by Thies and Lichtenstein with tubal abortion hemorrhage have demonstrated that theoretic preconceptions need not render one too timid.

Policlinico, Rome

May 5, 1918, **25**, No. 18

37 *Peritonsillar Abscess. G. Bilancioni.—p. 413.
38 *Lesion of Nasal Septum in Cocain Addicts. G. Turtur.—p. 417.
39 War Wounds of Recurrent Nerve. C. Chiri.—p. 419.

37. Peritonsillar Abscess.—Bilancioni remarks that phlegmons close to the tonsil are rather frequent in soldiers, so that he has had opportunity to study quite a number of them. He has become convinced that the Killian, Lemaitre and Ruault technics do not answer the purpose of radical treatment so well as to cut out the upper half, at least, of the tonsil. This ensures complete drainage; the lower portion of the tonsil can be left unmolested. The anatomic conditions do not favor extension of the phlegmon downward, while the conditions around the upper part of the tonsil invite retention of pus. This is the cause of the frequent relapses with other technics.

38. Nasal Lesion in Cocain Addicts.—Turtur has found necrotic ulceration of the septum common among those who snuff cocain. It develops early, within two or three months, and often entails perforation. This is liable to be attributed to some constitutional disease if the addiction is not known, and recruits have been rejected on this account alone, the history of the cases not being brought out clearly enough to explain matters.

Brazil-Medico, Rio de Janeiro

Feb. 23, 1918, **32**, No. 8

40 Eugregarina Parasites of Brazilian Arthropods. II. C. F. Pinto.—p. 57.
41 Medicolegal Study of Lesions of the Hymen. O. Freire.—p. 57.

March 9, 1918, **32**, No. 10

42 Physiology and Pathology of Menstruation. J. Adeodato.—p. 73.

March 16, 1918, **32**, No. 11

43 Ciliated Protozoa Found in Mammals. G. Hasselmann.—p. 81.
44 *Medicolegal Study of Epinephrin Content of Suprarenals. O. Sampaio.—p. 81. To be continued.

44. Epinephrin Content of Suprarenals in Sudden Death.—Sampaio writes from the Instituto Rodrigues at Bahia to describe tests made of the epinephrin content of the suprarenals as a means of estimating whether or not death had occurred suddenly. He has modified the technic devised by Cevidalli and Leocini for the purpose, using a colorimeter arrangement, with potassium chromate.

Cronica Medica, Lima, Peru

March, 1918, 35, No. 657

45 *Serotherapy for Vomiting of Pregnancy. R. F. Melgar.—p. 65.
46 Arteriosclerosis and Angina Pectoris of Alcoholic Origin. E. Odriozola.—p. 71.
47 Geographic Distribution of Leishmaniasis in America. E. Escomel. —p. 76. Continuation.

45. Serotherapy for Uncontrollable Vomiting of Pregnancy.—Melgar reviews the scanty literature on the treatment of the uncontrollable vomiting of pregnancy by subcutaneous injection of serum from another pregnant woman. A number of striking cases have been reported by Mayer and Linser, Fieux and others, and Melgar adds two more to the list. He injected 10 c.c. of serum from a healthy pregnant woman, near term, following with a second or third injection of 15 or 20 c.c. at two or three day intervals. One patient was a primipara of 22, the other had borne several children, and in both the vomiting had persisted rebellious to all other measures. The improvement was pronounced in a few hours. The pulse grew slower, the vomiting less severe and less frequent, and disappeared completely by the third day. Melgar cites further three cases published by Freund, Fieux and Udaeta in which normal horse serum cured a dermatitis or incoercible vomiting in a pregnant woman, but he had no success in the one case in which he used horse serum.

Siglo Medico, Madrid

March 23, 1918, 65, No. 3354

48 Suggestions for Reform in Medical Education. V. Prieto.—p. 221.
49 *Typhus in Portugal. V. M. Cortezo.—p. 225. To be continued.

March 30, 1918, 65, No. 3355

50 *Trauma of the Eye. E. Wieden.—p. 242.
51 First Known Case of Beriberi in Spain. F. F. Martinez.—p. 245.
52 Climate in Treatment of Pulmonary Tuberculosis. G. Trivino. —p. 248.
53 Extraneous Modifications in Syphilitic Papule, Sicilia.—p. 249.

49. Typhus in Portugal.—Dr. V. M. Cortezo was sent recently by the Spanish government as a member of a commission to investigate what the Portuguese authorities are doing in stamping out the epidemic of typhus at Oporto, in northwestern Portugal. The disease is not confined to the poorer classes. There was a fatal case in the hotel where the commission was lodging. Cortezo's report extols the hospital arrangements and the work of the Portuguese public health service in general, but the war and other recent circumstances have brought conditions of extreme poverty to the towns investigated. Of Oporto, Cortezo says: "There are few cities that can compare with this in respect to its receptibility for an epidemic of the kind. Poverty and pauperism, with all the evils in their train, grip the population, without food, without clothing, with detestable alimentation and without habits of cleanliness. About a third of the populace live in small, walled-in communities, promiscuously with domestic animals. These groups of dwellings without ventilation or light are called *ilhas*, probably from the Latin *insula*." In one of these *ilhas* he saw twenty-three persons sick with typhus, without care of any kind till they were rushed to the hospital. As Portugal is small and there is much traffic throughout, the disease soon spread to other points, notwithstanding the efforts of Ricardo Jorge, chief of the public health service. Several cases have developed among the physicians and subordinates of this service, but none have proved fatal. The nurses to care for the sick are recruited from those who have recovered from the disease. The mortality was only 10 per cent. at the time of his visit, but later reports from Vigo newspapers, as cited by the *Siglo Medico*, state that on a recent Sunday there were 100 new cases and all proved fatal. There were 400 sick in the hospital when Cortezo visited it. He was impressed with the nonsusceptibility of infants; mothers nursed their babies throughout the disease and the infants did not contract it. The hospital service is supplemented by convalescents' homes, one of which, with capacity for 200 patients, is in an outlying suburb. The commission emphasizes the necessity for a sanitary convention between Portugal and Spain as there is constant intercourse between the two countries, many workmen crossing the international bridge to their daily work.

50. Trauma of the Eye.—Wieden discusses what the practitioner should and should not do when called in case of trauma of the eye. In the majority of cases in rural districts of loss of vision from a simple erosion of the cornea or slight penetration of a scrap of dirt or stone or vegetable fiber, vision might have been saved if it had not been for infection of the lacrimal passages prior to the accident. The warmth, moisture and darkness enhance the virulence of germs in the obstructed lacrimal duct and in the lacrimal gland, and infection soon spreads to one or both eyes. On compressing the region of the lacrimal duct, a mucous or purulent fluid may exude from the lacrimal point or the sac forms a small tumor, like a cyst, the relaxed walls having lost their elasticity. Injection into the lacrimal point of physiologic salt solution, colored with methylene blue, or instillation of a 5 per cent. solution of a silver preparation will show whether the lacrimal duct is permeable, after the nostrils have been plugged with cotton, the head bent forward. The upper surface of the cotton will show the stain.

Wieden reiterates impressively the importance of every affection of the lacrimal passages as liable to doom to blindness in case of casual and otherwise harmless injury of the eye. Physicians everywhere should be on the lookout for lacrimal trouble, and educate the public in the peculiar dangers of even slight injuries of the eyes with infection installed in the lacrimal sac. When the lacrimal duct is freely permeable, the physician can soothe the pain by instillation of a few drops of a 2 per cent. solution of cocain, having the eye kept closed for a few minutes, then rinsing freely with physiologic saline or a weak antiseptic to clear out all foreign particles, concluding by applying petrolatum with a little boric acid and methylene blue. This lubricates and isolates the eye, and a dressing is then applied. The treatment after this belongs to the specialist. When the lacrimal duct was found obstructed, he always obtained good results from instillation of a few drops of optochin, as this has a specific action on the pneumococcus, the microbe usually responsible for lacrimal infection. When this drug is not available, he instills a 0.5 per cent. solution of zinc sulphate, and applies medicated petrolatum, but refrains on principle from bandaging the eye, as the secretions should have free outlet. He recalls to the practitioner that a magnifying glass is very useful in examining the eye for foreign particles.

Nederlandsch Tijdschrift voor Geneeskunde, Amsterdam

April 6, 1918, 1, No. 14

54 Electrocardiogram Varies with Speed of Impulse. S. de Boer. —p. 928.
55 *Convalescence Eosinophilia. D. Klinkert.—p. 941.
56 History of Medicine in the Netherlands. D. Schoute.—p. 945.
57 *Urticaria from Muscular Exertion. G. A. Prins.—p. 952.

55. Nature of Anaphylaxis and Convalescence Eosinophilia.—Klinkert remarks that the eosinophil count seems to run the same course in all infectious diseases. The eosinophils grow less in numbers as the disease progresses, until the acme has been reached and passed. Then they increase in numbers until the eosinophil count is above normal, and this post-crisis eosinophilia persists for some time after convalescence. He recalls that local eosinophilia accompanies the secretion of digestive ferments, and this suggests a connection between the normal digestion of food and the parenteral digestion of the invading bacteria. Convalescence eosinophilia may thus be regarded as an index of the secretion of ferments destined to digest the bacteria. The secretion of the gastro-intestinal digestive ferments is under the control of the autonomic nervous system, and the secretion of the ferments to digest the bacteria is likewise under the control of this nervous system. This plausible assumption is confirmed by the phenomena of anaphylactic shock. This shock is not the result of the circulation of the toxic split products of the albumin antigen, but these products circulating in the blood irritate the autonomic nervous system. This irritation is gradual and remains latent until the sudden introduction of a new unit of antigen upsets the precarious balance, and the anaphylaxis phenomena develop. Anaphy-

laxis is a cumulative toxic action from antigen. On account of the suddenness of the nervous discharge, the ferments are unable to aid efficiently in time. The anaphylactic shock may be defined as the baneful artificial caricature of the normal crisis. The eosinophilia in both is the index of the irritated condition of the autonomic nervous system. Postfebrile bradycardia may also be regarded as a phenomenon on the part of this nervous system.

Further testimony in this line is offered by recent research (Hirschstein, 1917) which has apparently demonstrated that when gastric juice and intestinal juice are formed under the influence of the vagus nervous system, a large amount of uric acid is formed at the same time. There is probably a similar formation of uric acid when specific immunity ferments are secreted under the influence of the autonomic nervous system. The urine in pneumonia on the day of the crisis contains an abnormally large proportion of uric acid. This has hitherto been ascribed to the destruction of leukocytes during resorption of the pneumonic exudate. But Klinkert thinks that this increased uric acid content is connected with the secretion of the specific antibodies. It is observed with other infectious diseases as well, at the turn for the better. In a case of typhoid, for example, the uric acid content of the urine jumped from 0.790 to 1.031 gm. at defervescence; in a case of pneumonia, from 0.815 to 1.495 gm. This increased uric acid content and the eosinophilia are thus, each of them, a phenomenon indicating the onset of convalescence. There is no retention of uric acid during fever; in fact, fever and hyperuricacidemia exclude each other. But as the temperature drops, uric acid accumulates in the blood, and is thrown off in the urine. In conclusion he reiterates the close analogy between the normal food-digestion process, with its secretion of digestive ferments, accompanied by eosinophilia and formation of uric acid, and the immunization process, with its specific secretion of ferments, its convalescence eosinophilia, and the uric acid output at the crisis. The participation of the autonomic nervous system in both processes sustains the assumption that gout can be regarded likewise as a neurosis of this system. This assumption is given a solid basis by the development of true gout in joints during convalescence from pneumonia and other infectious diseases.

57. **Urticaria After Muscular Exercise.**—Prins' patient is a girl of 15 who develops typical itching urticaria regularly after a dancing lesson and also after running or other muscular exercise. Dermographism is pronounced, as also a tendency to orthostatic albuminuria. No cause for the urticaria can be discovered unless it can be ascribed to toxic action from poisons generated in the muscles during muscular exercise. He ordered complete abstention from dancing and other exercise, and gave phosphorus and cod liver oil or calcium and tonics. The tendency to urticaria was thus broken up, and after the end of six months the restrictions were removed, without return of the urticaria, except one mild attack after hard running one hot day. He has since encountered a second case. This is in a physician and an emotional factor, besides the muscular effort, is evident in this case.

Ugeskrift for Læger, Copenhagen

April 18, 1918, 80, No. 16

58 *The Vitamins. E. Madsen.—p. 613.

April 25, 1918, 80, No. 17

59 Indications for Colloidal Silver. H. I. Bing.—p. 653.
60 *Case of Anaphylaxis. Kjelgaard.—p. 657.
61 *Duplicate Cases. O. Hamburger.—p. 658.

58. **The Vitamins.**—Among the practical points emphasized by Madsen is that a lactating woman must have food rich in vitamins. The lack of them may be responsible for certain pregnancy disturbances, uncontrollable vomiting, distaste for food, etc. As rachitis develops predominantly in the artificially fed, the lack of vitamins in the cow's milk or their destruction by boiling the milk, seems a plausible factor in rachitis. We do not know yet whether the scarlet fever virus, for example, survives moderate pasteurization. If the milk has to be sterilized during an epidemic, provision should always be made for supplying vitamins in some other form, meat juice for young infants; potato purée, or egg yolk for older children. In digestive troubles we must beware of not letting the diet get too poor in vitamins, as a diet that makes little demands on the digestive organs is generally poor in vitamins. Desiccation also destroys vitamins in fruit, vegetables, etc. This explains why an antidiarrheic diet keeps the patient so languid. The tea, rice water, etc., are peculiarly poor in vitamins, and special measures are necessary to correct this. A surplus of vitamins reduces the calory demand. Tagaki found that the men in the Japanese fleet gained in weight when the rations were modified to include more vitamins although it represented fewer calories. In the Danish prisons, when the bread ration was reduced and barley porridge given instead, the men gained in weight. Barley is richer in vitamins than rye and wheat.

Madsen warns that a lack of appetite is often the first symptom from a deficit in vitamins. He thinks there is much to suggest that a vitamin deficit is a factor in chlorosis anemia, neurasthenia, vasomotor disturbances, etc. In fevers, convalescence, etc., the necessity for an ample vitamin supply is imperative. It is possible that the mysterious benefit from cod liver oil may be due to an exceptional vitamin content. The commercial infant foods on the market are completely free from vitamins, and they must be added from some other source. In institutions where the food is cooked in large portions at a time, there is liable to be a deficit in vitamins.

There is no doubt, he adds, that beriberi occurs much more commonly in all countries than has been hitherto appreciated, but it is not recognized, as no one looks for it outside the tropics. The war edema without albuminuria may be a rudimentary form of beriberi. It is possible that this may be true also of many cases of peripheral neuritis and heart weakness. Among the peculiarly vitamin-rich foods he lists butter and cheese, egg yolk, raw meat and fresh meat juice and soup. Steamed meat and fish retain their vitamins better than when boiled. Meat extracts are free from vitamins. In grains they occur in a series with rice at the lowest and barley at the highest point; in rice the vitamin occurs only in the hull, in barley in both hull and kernel. The finer the flour is bolted, the less the proportion of vitamins in it. Legumes and potatoes are rich in vitamins, but they pass mostly into the water in which they are boiled, so this water should be used in the preparation of the food. Dried and cooked vegetables have no vitamins. Fresh fruit is rich in vitamins, and in the acid fruits they seem to be especially thermostable. It is still undecided whether wine and oil contain vitamins.

60. **Anaphylaxis.**—Kjelgaard remarks that when one has been giving diphtheria antitoxin for thirty years without the slightest by-effects or complications, an injection of antitoxin seems a very harmless intervention. But a recent experience has upset this belief in him. Seven years ago he gave himself a preventive injection after a child had coughed false membranes into his face, and recently he took another injection for the same reason, some of the membrane tissue having got into his eye. The sixth day intensely itching urticaria developed, preventing sleep, and the face, lips and throat swelled, the pulse became imperceptible, and deep breathing was impossible. There were pains in the eye as if an insect had got in the eye. As these symptoms subsided, pains and tenderness developed in joints and tendons, with fleeting contractures. The symptoms gradually wore off in the course of ten or twelve days leaving merely lassitude in the legs. The dose of antitoxin was 4,000 units; it was supposed to be four months old. The patient injected just before himself showed no symptoms from the injection except slight local urticaria.

61. **Duplicate Cases.**—Hamburger describes four pairs of unusual cases which occurred in close sequence, and the experience with the first gave the clue to successful treatment in the twin case, especially with actinomycosis. The patient in this second case seemed to have merely pneumonia except for a tender point on one rib and this swelled a little. The surgeon was rather skeptical when called on to open this small tumor, but this revealed typical actinomycosis.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JANUARY-JUNE, 1918

The following journals have been abstracted in the Current Literature Department of THE JOURNAL during the past six months. Any of the foreign journals, except those starred, will be lent by THE JOURNAL to subscribers in the United States and to Fellows of the American Medical Association for a period not exceeding three days. Only one journal may be borrowed at a time. Requests for periodicals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. Domestic journals can be obtained by sending the approximate amount direct to the respective publishers. Thus most of the journals indexed are accessible to the general practitioner, no matter where he may be located.

Acta Scholae medicinalis universitatis imperialis in Kioto. Irregular. 1.50 yen. Tokyo.

American Journal of Anatomy. Bi-m. $7.50. 36th St. and Woodland Ave., Philadelphia.

American Journal of Diseases of Children. M. $3. American Medical Association, 535 N. Dearborn St., Chicago.

American Journal of Insanity. Q. $5. Johns Hopkins Press, Baltimore.

American Journal of the Medical Sciences. M. $5. Lea & Febiger, 706 Sansom St., Philadelphia.

American Journal of Obstetrics and Diseases of Women and Children. M. $5. William Wood & Co., 51 Fifth Ave., New York.

American Journal of Ophthalmology. M. $10. 7 W. Madison St., Chicago.

American Journal of Orthopedic Surgery. M. $4. 126 Massachusetts Ave., Boston.

American Journal of Physiology. M. $5. Johns Hopkins Medical School, Baltimore.

American Journal of Public Health. M. $3. 126 Massachusetts Ave., Boston.

American Journal of Roentgenology. M. $5. 69 E. 59th St., New York.

American Journal of Syphilis. Q. $5. C. V. Mosby Co., St. Louis.

American Review of Tuberculosis. M. $3. 2419 Greenmount Ave., Baltimore.

Anales de la Facultad de medicina, Montevideo. Bi-m. $2. Montevideo.

Anales de la Facultad de medicina, Universidad de Lima. Bi-m. 6 soles. Lima, Peru.

Annales de gynécologie et d'obstétrique. M. 22 francs. Paris.

Annales de médecine. M. 23 francs. Paris.

Annali d'igiene. M. 20 lire. Rome.

Annals of Medical History. Q. $6. Paul B. Hoeber, 67 E. 59th St., New York.

Annals of Surgery. M. $6. J. B. Lippincott Co., 227 S. 6th St., Philadelphia.

Annals of Tropical Medicine and Parasitology. Q. $5. Liverpool.

Archives of Diagnosis. Q. $2. Rebman Co., 141 W. 36th St., New York.

Archives of Internal Medicine. M. $4. American Medical Association, 535 N. Dearborn St., Chicago.

Archives des maladies de l'appareil digestif et de la nutrition. M. 14 francs. Paris.

Archives des maladies du cœur, des vaisseaux et du sang. M. 17 francs. Paris.

Archives médicales belges. M. 18 francs. Paris.

Archives de médecine des enfants. M. 18 francs. Paris.

Archives de médecine et de pharmacie militaires. M. 40 francs. Paris.

Archives mensuelles d'obstétrique et de gynécologie. M. 25 francs. Paris.

Archives of Ophthalmology. Bi-m. $5. G. P. Putnam's Sons, 2 W. 45th St., New York.

Archives of Pediatrics. M. $3. E. B. Treat & Co., 45 E. 17th St., New York.

Archives of Radiology and Electrotherapy. M. $5. London.

Archivos españoles de pediatria. M. 18 pesetas. Madrid.

Boletin de la asociación médica de Puerto Rico. Q. San Juan, Porto Rico.

Bollettino dell'istituto sieroterapico milanese. Milan.

Boston Medical and Surgical Journal. W. $5. 126 Massachusetts Ave., Boston.

Brain. Irregular. $4. London.

Brazil-medico. W. 20 milreis. Rio de Janeiro.

Bristol Medical and Chirurgical Journal. M. 6s. Bristol.

British Journal of Children's Diseases. Q. $3. London.

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This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "C," Correspondence; "T," Therapeutics; "Ml," Medicolegal; "P," Propaganda for Reform; "ME," Medical Economics; "ab," abstract; the star (*) indicates an "Original Article" in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths" and "Society Proceedings" are indexed under these titles at the end of the letters "B," "D" and "S." Matter pertaining to the Association is indexed under "American Medical Association."

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SOCIETIES

A.—Association.
Acad.—Academy.
Am.—American.
Coll.—College.
Conf.—Conference.
Cong.—Congress.
Conv.—Convention.
Dist.—District.
Hosp.—Hospital.
Internat.—International.
M.—Medical or Medicine.
Nat.—National.
Phar.—Pharmaceutical.
Phys.—Physician.
Ry.—Railway.
S.—Society.
Surg.—Surgical, Surgeon or Surgery.

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